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U.S. CONGRESS HOUSE. COMMITTEE ON EXPENDITURES IN THE EXECUTIVE DEPARTMENTS.
(HEARING ON H.R. 5182)
UNITED MEDICAL ADMINISTRATION

MARCH, JUNE, JULY 1950

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UNITED MEDICAL ADMINISTRATION

HEARING on H.R. 5182 March, June, July 1950

BEFORE THE

COMMITTEE ON EXPENDITURES IN THE EXECUTIVE DEPARTMENTS,

U. S. Congress. HOUSE OF REPRESENTATIVES

EIGHTY-FIRST CONGRESS

SECOND SESSION

ON

H. R. 5182

A BILL TO CONSOLIDATE CERTAIN HOSPITAL, MEDICAL, AND PUBLIC HEALTH FUNCTIONS OF THE GOVERNMENT IN A UNITED MEDICAL ADMINISTRATION

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MARCH 29, JUNE 13, 14, 22, AND JULY 12, 1950

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UNITED MEDICAL ADMINISTRATION

WEDNESDAY, MARCH 29, 1950

House of Representatives,
Subcommittee of the Committee on Expenditures
in the Executive Departments,
Washington, D. C.

The subcommittee met, pursuant to call, at 10 a. m., in room 1501 New House Office Building, the Honorable William L. Dawson, chairman of the committee, presiding.

The Chairman. Will the committee come to order.

The committee is meeting for consideration of H. R. 5182, a bill to consolidate certain hospital, medical, and public health functions of the Government in a United Medical Administration. This bill is filed by our most distinguished member of this committee and of the Congress, a man of broad experience, the minority leader of this committee, Congressman Hoffman, of Michigan. It seeks to put into effect one of the recommendations of the Hoover Commission to the end that there should be established in the Government a United Medical Administration to take care of some of the medical problems of our Government.

I am going to dispense with a reading of the bill that seeks to effectuate that at this time in order that we might deal with the principle itself. We have received many messages pro and con on this matter. It is one that cannot be effectuated by a Presidential plan of reorganization, and thereby necessitates legislation on the part of the Congress, and this bill is drawn for that purpose.

(H. R. 5182 follows:)

[H. R. 5182, 81st Cong., 1st sess.]

A BILL To consolidate certain hospital, medical, and public health functions of the Government in a United Medical Administration

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "United Medical and Hospital Administration Act."

UNITED MEDICAL ADMINISTRATION

Sec. 2. (a) There is hereby established an agency in the executive branch of the Government which shall be known as the United Medical Administration, at the head of which shall be an Administrator who shall be appointed by the President by and with the advice and consent of the Senate, receive compensation at the rate of $ ——— per annum, and perform his functions subject to the direction and control of the President.

(b) There shall be in the United Medical Administration three Assistant Administrators, who shall be appointed by the President by and with the advice and consent of the Senate, receive compensation at the rate of $——— per annum, and perform such functions as the Administrator shall direct.

(c) The Administrator is authorized, subject to the civil-service laws, rules, and regulations, to employ such personnel (other than those provided for in section 5 of this Act) as may be necessary to carry out the provisions of this Act.

(d) The Administrator shall establish special advisory and other committees and groups composed of members of the medical and allied scientific professions, whose duty shall be to advise the Administrator, or such officers of the United Medical Administration as the Administrator may designate, with respect to matters pertinent to the duties of the United Medical Administration. The number, terms of service, compensation, and allowances to members of such advisory committees and groups shall be prescribed by the Administrator.

(e) The United Medical Administration shall be entitled to the free use of the United States mails to the same extent as the executive departments.

(f) The Administrator shall make an annual report to the President and to the Congress.

ADVISORY BOARD

SEC. 3. (a) There is hereby established an advisory board to the Administrator, consisting of the Administrator of Veterans' Affairs, the Surgeon General of the Army, the Surgeon General of the Navy, and the Air Surgeon, or their designated representatives. The Administrator shall meet with the advisory board at least once in each calendar month, and consult with such board with regard to policies and proposed policies of the United Medical Administration.

(b) The advisory board is authorized to employ an executive secretary, and such clerical and stenographic personnel to assist the executive secretary as may be necessary.

CONSOLIDATION OF MEDICAL AND HOSPITAL FUNCTIONS IN ADMINISTRATION

SEC. 4. (a) There shall be transferred to the United Medical Administration—

(1) all functions and facilities of the Public Health Service, all functions of the Surgeon General of the Public Health Service, and all functions of the Federal Security Administrator in relation to the foregoing;

(2) all hospitals of the Veterans' Administration, all facilities of such Administration for out-patient services to veterans, and all functions of the Veterans' Administration and the Administrator of Veterans' Affairs in relation to the foregoing;

(3) all general hospitals of the Army in the continental United States (excluding Alaska) except one such hospital designated by the Secretary of the Army to be retained as an Army medical center; all station hospitals of the Army in the continental United States (excluding Alaska) except station hospitals at outlying posts designated by the President as being so located that other hospitals of the United Medical Administration would not be near enough to provide the care required; and all functions of the Secretary of Defense, the Secretary of the Army, and the Surgeon General of the Army in relation to the foregoing;

(4) all general hospitals of the Navy in the continental United States (excluding Alaska) except one such hospital designated by the Secretary of the Navy to be retained as a Navy medical center; all dispensaries of the Navy in the continental United States (excluding Alaska) denominated "general dispensaries"; and all other dispensaries of the Navy in the continental United States (excluding Alaska) except dispensaries at outlying posts designated by the President as being so located that other hospitals of the United Medical Administration would not be near enough to provide the care required; and all functions of the Secretary of Defense, the Secretary of the Navy, and the Surgeon General of the Navy in relation to the foregoing;

(5) all station hospitals of the Air Force in the continental United States (excluding Alaska) except one such hospital designated by the Secretary of the Air Force to be retained as an Air Force medical center, and except station hospitals at outlying posts designated by the President as being so located that other hospitals of the United Medical Administration would not be near enough to provide the care required; and all functions of the Secretary of Defense, the Secretary of the Air Force, and the Air Surgeon in relation to the foregoing;

(6) the four civilian hospitals in the Canal Zone under the jurisdiction of the Panama Canal, the dispensaries, clinics, health centers, laboratories, and other facilities of the Department of Health of the Canal Zone, and all

functions of the Panama Canal and such Department of Health in relation to the foregoing;

(7) Saint Elizabeths Hospital in the District of Columbia, and all functions of the Federal Security Administrator in relation thereto.

(b) Functions transferred to the United Medical Administration under subsection (a) shall be vested in the Administrator, and be exercised by him through such officers and units of the United Medical Administration as he may designate.

(c) The property, records, and unexpended balances of appropriations, allocations, and other funds (available or to be made available), and the personnel, which the Director of the Budget shall determine relate primarily to the functions transferred by subsection (a) are transferred to the United Medical Administration for use in the administration of the functions so transferred. Any of the personnel transferred which the Administrator of the United Medical Administration shall find to be in excess of the personnel necessary for the administration of the functions transferred to the United Medical Administration shall be retransferred under existing law to other positions in the Government or be separated from the service. When personnel of the armed forces are transferred under this subsection, such transfers shall be only for such periods as the President determines may be necessary to assure that the hospitals tranferred remain at all times adequately staffed.

(d) Any member of the Army, Navy (including the Marine Corps), or the Air Force, or of any reserve component of either when in an active-duty status, may be assigned or detailed for duty or training in the United Medical Administration. The assignment or detail, or the transfer, of any such member to the United Medical Administration shall be without loss of or prejudice to his status in the Army, Navy, or Air Force, or reserve component thereof.

PROFESSIONAL PERSONNEL

SEC. 5. (a) There shall be established in the United Medical Administration a professional career service to be known as the United Health and Medical Services. Persons appointed in the United Health and Medical Services shall be subject to the provisions of and entitled to the benefits under the Civil Service Retirement Act of May 22, 1920, as amended, but otherwise shall be subject only to the provisions of this section and the rules and regulations of the President and of the Administrator promulgated or issued pursuant thereto.

(b) Any person to be eligible for appointment in the United Health and Medical Services must—

(1) be a citizen of the United States;

(2) for appointment as a physician—hold the degree of doctor of medicine or of doctor of osteopathy from a college or university approved by the Administrator, have completed an approved internship, and be licensed to practice medicine, surgery, or osteopathy in one of the States or Territories of the United States or in the District of Columbia;

(3) for appointment as a dentist—hold the degree of doctor of dental surgery, or its equivalent, from a college or university approved by the Administrator, and be licensed to practice dentistry in one of the States or Territories of the United States or in the District of Columbia;

(4) for appointment as a nurse—have successfully completed a full course of nursing in a recognized school of nursing, approved by the Administrator, and be registered as a graduate nurse in one of the States or Territories of the United States or in the District of Columbia;

(5) for appointment to auxiliary professional positions—hold a bachelor's degree from a college or university approved by the Administrator and have received, either in graduate study or otherwise, special training in scientific subjects determined by the Administrator to be related to the health and medical field and to qualify such person for such position;

(6) for appointment to other auxiliary positions—have such training and experience as health technologists or administrators, and have such other qualifications, as the Administrator may prescribe.

(c) Appointments in the United Health and Medical Services shall be made only after qualifications have been satisfactorily established in accordance with the regulations prescribed by the Administrator. Initial appointments shall be for appropriate probationary periods, to be prescribed by the Administrator, and the record of each person serving under such an appointment shall be re-

viewed from time to time by an appropriate board, appointed in accordance with regulations of the Administrator, and if such board shall find the appointee not fully qualified and his service not fully satisfactory, he shall be separated from the service.

(d) Promotions of persons within the United Health and Medical Services shall be made only after examination given in accordance with regulations prescribed by the Administrator. Ordinary promotions within grade may be made in increments of the minimum pay of the grade in accordance with regulations prescribed by the Administrator.

(e) Notwithstanding any other law, the Administrator shall by regulation prescribe the hours and conditions of employment, and leaves of absence, of persons in the United Health and Medical Services.

(f) The Administrator, under such regulations as he shall prescribe, shall from time to time appoint boards in the United Health and Medical Services, to be known as disciplinary boards, each such board to consist of not less than three nor more than five persons in the United Health and Medical Services, senior in grade, to determine, on notice and fair hearing, charges of inaptitude, inefficiency, or misconduct of any person employed therein. The Administrator shall appoint the chairman and secretary of the board, each of whom shall have authority to administer oaths. The Administrator may designate or appoint one or more investigators, to assist each disciplinary board in the collection and presentation of evidence. Any person answering charges before a disciplinary board may be represented by counsel of his own choice. A disciplinary board, when in its judgment charges are sustained, shall recommend to the Administrator suitable disciplinary action, within limitations prescribed by the Administrator, which may include reprimand, suspension without pay, reduction in grade, or discharge from the United Health and Medical Services. The Administrator shall either approve the recommendation of the board, approve the recommendation with modification or exception, approve the recommendation and suspend further action at the time, or disapprove the recommendation. He shall cause to be executed such action as he approves, and his decision shall be final.

(g) The power, functions, and duties of the Administrator under this section shall be subject to and be exercised in accordance with such rules relating to personel as may be prescribed by the President under section 1753 of the Revised Statutes, as amended.

COMPENSATION SCHEDULES

Sec. 6. (a) Within the limits of such maximum and minimum rates of basic compensation for civilian officers and employees in the executive branch of the Government as Congress may from time to time prescribe, the President is authorized to promulgate from time to time schedules and rules governing the rates of basic compensation to be paid to persons in the United Health and Medical Services. Rules promulgated by the President pursuant to this section shall, to the extent prescribed by the President therein, supersede existing laws, regulations, orders, and directives fixing the rates of pay of the officers and employees covered thereby, or providing for placing their positions in grades or classes for pay purposes.

(b) The Administrator may, as hereinafter provided, rate any person holding a position in the United Health and Medical Services as a specialist, but no person shall at any one time hold more than one such rating. A person so rated as a specialist shall receive, in addition to his basic pay, an allowance equal to 25 per centum of such pay, if and for as long as the major part of his duties involves the practice of such specialty (as determined by the Administrator).

(c) A person serving as a physician in the United Health and Medical Services may be rated as a specialist only if he is certified as a specialist by an American specialty board, recognized by the Administrator where such boards exist, or if no such boards exist, only if he has been examined and found qualified by a board appointed by the Administrator from specialists in the United Health and Medical Services holding ratings in the specialty to which the candidate aspires. If there should be an insufficient number of specialists in the United Health and Medical Services rated in the specialty in question, who are readily available to constitute such a board, the Administrator may substitute consultants with comparable qualifications employed under section 8 of this Act.

(d) A person holding a position other than that of physician may be rated as a specialist only if he is possessed of such advanced or postgraduate training making him specially expert in a particular subdivision of the health field, as the Administrator may prescribe.

DETAIL OF PERSONNEL IN THE UNITED HEALTH AND MEDICAL SERVICES

SEC. 7. (a) The Administrator is authorized to place employees of the United Health and Medical Services in schools of the Army, the Navy, and Air Force, and in civil institutions of learning, with the consent of the authorities concerned, for the purpose of increasing the professional knowledge or technical training of the personnel of the United Health and Medical Services, and, subject to available appropriations, to pay for tuition, transportation, and educational fees of personnel so placed. A person authorized to attend a course of training shall be required to reimburse the Administrator for the expenses thereof if such person voluntarily leaves the United Health and Medical Services within a period, beginning with the completion of such course, less than three times as long as the period of such training.

(b) Persons in the United Health and Medical Services may, with the approval of the Administrator, as part of their duties attend meetings of associations for the promotion of medical and related sciences, and the Administrator is authorized to pay the expenses, except membership fees, of such attendance.

TEMPORARY OR PART-TIME PERSONNEL

SEC. 8. The Administrator may employ, without regard to the civil-service laws or the Classification Act of 1923, as amended, or any of the other provision of this Act, physicians, dentists, and nurses on a temporary full-time, part-time, or fee basis, and such other professional, technical, clerical, skilled, and unskilled personnel on a temporary full-time or part-time basis at such rates of pay as he may prescribe. No temporary full-time appointment shall be for a period of more than ninety days.

TEMPORARY PROVISIONS

SEC. 9. (a) The Department of Medicine and Surgery of the Veterans' administration is abolished, except that persons holding positions in the Medical Service, the Dental Service, the Nursing Service, or the Auxiliary Service of such Department, who are transferred to the United Medical Administration under the provisions of this Act, shall be continued in their present positions until the Administrator shall have determined their qualifications for appointment in the United Health and Medical Services.

(b) The Public Health Service, transferred to the United Medical Administration under section 4, shall continue as such in the United Medical Administration, except that no new commissions therein shall be issued, and any officer therein may resign his commission and accept appointment in the United Health and Medical Services.

EFFECTIVE DATE OF TRANSFERS

SEC. 10. The transfers provided for in section 4 of this Act shall take effect sixty days after the date of the enactment of this Act.

The CHAIRMAN. We have with us one of our distinguished Members of Congress who has expressed a desire to testify at this time on this matter. He is the Congressman from Minnesota, Congressman Hagen, who will testify at this time on this matter.

Mr. HAGEN. Chairman Dawson, before we start if you are willing, being in favor of accuracy rather than praise, if you will just strike the adjectives and adverbs out of that first statement.

The CHAIRMAN. I could not make a statement unless I expressed my appreciation for your long service in the Congress.

Mr. HAGEN. That is fine, but we do not want it of record.

The CHAIRMAN. Will you proceed, Congressman?

STATEMENT OF HON. HAROLD C. HAGEN, REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. HAGEN. Mr. Chairman and members of the committee, with your consent I would like to file my prepared statement. I do not want to take up your time. I see you have a lot of witnesses here.

The CHAIRMAN. Do you have sufficient copies to provide each member?

Mr. HAGEN. I will provide for those within the next hour or two.

Mr. Chairman, I want to go on record here, and I will file my statement with you and not take any more of your time, as being opposed to the consolidation because in my opinion I feel that there will be less efficiency, less economy, and more red tape in the handling of veterans' affairs than we have at the present time. Up to now we have built up a fine administration, we have built up good hospitalization. Most of the veterans throughout the country are happy and pleased with this set-up at the present time. All of the veterans' organizations in my opinion and from my own knowledge are for the present set-up. They do not want it disturbed or changed. They fought for many years to bring it up to the point of efficiency that there is today, and they are satisfied to a large extent and to a large degree.

Of course they know that some improvements can be made, but they do not want to make any major change at this time. So with that, Mr. Chairman, I want to file the written statement that I have prepared and thank you for your time.

(The statement referred to follows:)

STATEMENT OF HON. HAROLD C. HAGEN OF THE NINTH CONGRESSIONAL DISTRICT OF MINNESOTA

Mr. Chairman, I appreciate very much having the opportunity to appear before your committee and voice my views in opposition to the provisions of the bill under consideration, H. R. 5182, insofar as they affect the present administrative powers and program of the Veterans' Administration.

Before doing so, I wish to state, that with few exceptions, I am heartily in accord with the recommendations of the Hoover Commission. That Commission has done an excellent job in their efforts to seek ways and means to economy and efficiency in the operation of the Federal Government.

It was President Hoover, in his state of the Union message to the Congress in 1929, the beginning of the second session of the Seventy-first Congress that stated: "I am convinced that we will gain in efficiency, economy, and more uniform administration, and better definition of national policies, if the Pension Bureau, the National Home for Volunteer Soldiers, and the Veterans' Bureau are brought together under a single agency."

This consolidation in the interest of efficiency and economy, and to prevent delay and confusion in adjudicating veterans' claims, was effectuated by the Congress in 1930, when it created the present independent establishment known as the United States Veterans' Administration. This agency has administrative control, direction, and management of the various agencies consolidated.

I do not believe that there is a single American who would dispute the statement of former Vice President Dawes that: "No emergency of war itself was greater than is the emergency which confronts the Nation in its duty to care for those disabled in its service * * *." The foregoing is an excerpt from the report submitted by General Dawes, as chairman of a special committee appointed by the late President Harding in April 1921 to investigate the chaotic conditions confronting our veterans at the time, and recommend remedial measures. That investigation, the report and its recommendations resulted in the enactment of Public Law No. 47, Sixty-seventh Congress, approved August 9, 1921, which established an independent bureau under the direction and control of the President, known as the Veterans' Bureau.

Prior to the establishment of the Veterans' Bureau, the Federal Board for Vocational Education of the Interior Department, handled the retraining of veterans, the United States Public Health Service was in charge of physical examinations and hospitalization. The Bureau of War Risk Insurance had charge of the following phases of the veterans' care: (1) Marine insurance covering crews, cargoes and vessels, (2) allotment and allowance for enlisted personnel, (3) compensation for service-connected disabilities, and (4) war-risk insurance (term insurance), and United States Government life insurance (converted insurance).

The Bureau of War Risk Insurance, and the Public Health Service were both in the Treasury Department and under the jurisdiction of the same Assistant Secretary. That set-up required a veteran who knew nothing about Government organizations to contact at least two Federal bureaus on any type of benefit to which he was entitled. At that time the Government was dealing with less than 5,000,000 veterans, and were granting fewer benefits requiring physical examinations than we are today. At present we are dealing with approximately 19,000,000 veterans and physical examinations are required on all claims for compensation, insurance, pension, vocational training, cars for amputees, paraplegic homes, et cetera.

It follows that if it was found in 1921 to be absolutely unworkable to administer to the needs of 5,000,000 veterans with only a few benefits requiring physical examinations in those days, how can anyone expect to administer to the needs of approximately 19,000,000 veterans with six or seven benefits requiring physical reports, if the hospitals and other medical activities are returned to the program in effect prior to the establishment of the Veterans' Bureau on August 9, 1921.

The answer should be obvious to any fair-minded citizen who believes in efficiency and economy in Government operations and abhors the useless and wasteful expenditure of public funds.

This bill (H. R. 5182) if enacted into law would return us to the same chaotic conditions that existed prior to 1921, because it provides in—

"SEC. 4. (a) There shall be transferred to the United Medical Administration—

"(2) all hospitals of the Veterans' Administration, all facilities of such Administration for out-patient services to vterans, and all functions of the Veterans' Administration and the Administrator of Veterans' Affairs in relation to the foregoing; * * *

"(b) Functions transferred to the United Medical Administration under subsection (a) shall be vested in the Administrator, and be exercised by him through such officers and units of the United Medical as he may designate."

The Congress took a far-reaching step in 1946, when it established in the Veterans' Administration a Department of Medicine and Surgery, under the provisions of Public Law No. 299, Seventy-ninth Congress, approved January 3, 1946. The enactment of this law was largely due to the foresight and efforts of a great American, an outstanding leader and authority in his chosen profession of medicine and surgery, Dr. Paul Hawley, formerly head of the Medical Corps of the United States Army and a close personal friend of Gen. Omar Bradley, the then Administrator of Veterans' Affairs. General Hawley, because of his prestige and leadership in his chosen field of endeavor was able to attract into its career service leaders and authorities in the several fields of medicine and surgery. The wise and efficient policies initiated by General Hawley have been continued by his able successor, Dr. Paul B. Magnuson, an equally efficient administrator and leader in his chosen profession and, incidentally, a native of St. Paul, Minn. This Department of Medicine and Surgery since its establishment has rendered efficient and courteous service, which has received the approbation of professional men and women as well as our veterans.

The pending bill (H. R. 5182) also would destroy this very fine and efficient organization, because it provides in:

"SEC. 9. (a) The Department of Medicine and Surgery of the Veterans' Administration is abolished, except that persons holding positions in the Medical Service, the Dental Service, the Nursing Service, or the Auxiliary Service of such Department, who are transferred to the United Medical Administration under the provisions of this Act, shall be continued in their present positions until the Administrator shall have determined their qualifications for appointment in the United Health and Medical Services."

Mr. Chairman, I am opposed to the separation of hospital and other medical activities from the rest of the Veterans' Administration organization because

such a separation will be more costly, than the present system and will bring about chaotic conditions in what is now a flexible, smooth-operating program that gives prompt, courteous, and sympathetic service to our veterans and their dependents under the able and efficient leadership of our present Administrator of Veterans' Affairs, Gen. Carl R. Gray, Jr., a citizen of my home State of Minnesota.

This observation and view is based upon knowledge and experience gained in the handling of thousands of claims for veterans and their dependents during the 8 years I served at Secretary, to my predecessor, the late Honorable Richard T. Buckler, as well as my four terms of service as the Representative of the Ninth Congressional District of Minnesota in the Congress of the United States.

I strongly urge and recommend that this committee give special study and consideration to that portion of General Gray's report in his official capacity as Administrator of Veterans' Affairs, that he submitted to the President's Advisory Committee on Management Improvement, on January 17, 1950, wherein he stated:

"Many practical reasons exist to support the conclusion that the present integrated system of operation under a single agency is the best method for attaining efficiency and economy in the administration of veterans' programs. For example, it has been found necessary in the administration of various types of benefits to associate the records of each individual veteran so that complete consideration may be given to each type of claim, thus insuring greater protection to the Government as well as the claimant in testing the accuracy and sufficiency of proof in connection with claims for more than one benefit. These records also contain certain information which may be needed to determine entitlement to several benefits provided by law. It is not possible to determine in advance for what purpose certain information may be needed at some future time, and accordingly, it is necessary that all evidence in each individual folder be retained for possible future use. Separation of the benefit programs for veterans would require the submission by claimants of duplicate items of evidence to each separate agency. Moreover, a tremendous volume of day-to-day reference between the independent agencies would be required."

That statement, Mr. Chairman, of our able and efficient Administrator of Veterans' Affairs, General Gray, is, in my opinion, sufficient in itself in providing the reasons why the pending bill (H. R. 5182) should not be favorably reported by your committee, insofar as they affect the present administrative powers and program of the Veteran's Administration. I thank you.

The CHAIRMAN. Just a moment, Congressman.

Mr. HOFFMAN. You will come back later, I assume, for further questioning after we hear other witnesses?

Mr. HAGEN. I will be glad to do that.

Mr. HOFFMAN. Were you in favor of the unification bill where we attempted to unite, for economy and efficiency, the armed services?

Mr. HAGEN. Yes, I voted for that.

Mr. HOFFMAN. Is there any reason why the same procedure would not work here?

Mr. HAGEN. In my opinion it is doing very well at present.

Mr. HOFFMAN. Yes. I noticed you stated that the veterans were very happy over the present set-up. Do you not get many complaints from veterans with reference to the handling of their claims and the delay?

Mr. HAGEN. Very few, sir. In fact, I have had quite a few commendable letters in the last year or so of the treatment received at a number of veterans hospitals.

Mr. HOFFMAN. In the last year before this matter came up?

Mr. HAGEN. In the last several years, sir.

Mr. HOFFMAN. I do not doubt your word, but I have not received a single letter of that kind until this issue came up.

Mr. HAGEN. Especially the Minneapolis hospital, and Fargo, N. D., hospital.

Mr. HOFFMAN. You mean individual veterans wrote you saying they had received good treatment at this or that hospital?

Mr. HAGEN. Yes, both at Minneapolis and Fargo, N. D. There has been very little complaint in the last several years. This was some years ago, and I have been here about 16 years.

Mr. HOFFMAN. It takes about a fourth or a fifth of my time to take care of complaints of veterans and against the Veterans' Administration. Maybe I am unfortunate.

Mr. HAGEN. I have had a lot of complaints of a personal nature of cases that we attempt to follow through and it takes a lot of time. By the way, one case took 12 years and we finally got it settled satisfactorily for the veteran. Mr. Hoffman, I will be glad to come back and develop this with you, and I appreciate your views on it. I happen to be opposed to the consolidation, and I will be glad to answer any questions which I come back after I have filed my statement.

Mr. HOFFMAN. When you say you appreciate my views, at the moment I have none. The bill was written by the Hoover Commission's attorneys and sent up to me, and because there was a demand that we take some action on the recommendation of the Hoover Commission, I introduced 11 bills all sent up by them and some of which I have never to this day read and do not propose to read until the hearing comes up.

Mr. HAGEN. I know you have always taken an open mind on these things until you have heard the evidence.

Thank you, sir.

The CHAIRMAN. Did you have a question to ask the witness, Mr. Roosevelt? Mr. Lanham?

Thank you very much, Congressman.

Mr. RICH. May I ask him a question?

The CHAIRMAN. Pardon me, Mr. Rich.

Mr. RICH. You made mention of the fact that you believed that they have efficiency in the administration of these hospitals. What can you say in reference to the economy?

Mr. HAGEN. Mr. Rich, I have no knowledge of the other hospitals outside of those in my general area, Minnesota and North Dakota. Those seem to be operating quite efficiently and the treatment given to the veteran has been very satisfactory.

The CHAIRMAN. Mr. Pfeifer?

Thank you very much. We also thank you for your offer to permit us to recall you for questioning after the filing of your statement.

Mr. HAGEN. Thank you, gentlemen.

The CHAIRMAN. At this time I want to present as our next witness Mr. Miles D. Kennedy, who is national legislative director for the American Legion.

STATEMENT OF MILES D. KENNEDY, NATIONAL LEGISLATIVE DIRECTOR, THE AMERICAN LEGION

Mr. KENNEDY. Good morning, Mr. Chairman and gentlemen of the committee. I do not intend to offer any testimony, Mr. Chairman, but I would like to tell you that we have four witnesses here who will testify before you and all of them will submit written statements.

At this time I would like to introduce to you our national commander, a gentleman who was elected commander of the American Legion at our 1949 convention held at Philadelphia last August and September, and who is the first World War II man to have the honor of heading the national organization of the American Legion.

At this time, without any further ado and in the interest of saving time, it is my honor and privilege to present to you—

The CHAIRMAN. Once having submitted yourself as a witness, you are subject to be questioned by any member of the committee who wishes to question you. Before you call the next witness, are there any questions of this witness at this time?

Mr. HOFFMAN. I have none.

The CHAIRMAN. Mr. Harvey? Mr. Rich? Mr. Pfeiffer? Mr. Lanham? Mr. Roosevelt?

Thank you, you may proceed.

Mr. KENNEDY. At this time I would like to introduce our national commander, Mr. George N. Craig.

STATEMENT OF GEORGE N. CRAIG, NATIONAL COMMANDER, THE AMERICAN LEGION

Mr. CRAIG. Mr. Chairman and members of the committee, I have a prepared statement here. We have enough copies for each member of the committee.

I would like to express the gratitude of the American Legion to your committee for the privilege of coming here to discuss H. R. 5182, which is an outgrowth of the Hoover Commission recommendations that affect the Veterans' Administration.

Since 1919 my predecessors in the American Legion and our legislative and rehabilitation representatives have conferred with Members of the Congress in support of measures which we have considered as having merit, and which were consonant with the welfare of our Nation. The confidence that Congress heretofore has had in our judgment of the worth of measures affecting the vast field of veterans' benefits has been demonstrated on the many occasions when the Congress has enacted legislation which the American Legion supported.

We have definitely done nothing in the past, we are doing nothing at this time, nor shall we in the future do anything to violate the confidence that has been built up. We fully realize our responsibility to the people, to you, and to the veterans, and it is in that light that we come here to explain our position in regard to H. R. 5182.

Lest the unwarranted criticism be repeated that our position is taken without regard to the thinking of our general membership, permit me to say that we come before you at the direction of the national executive committee and at the direction of the delegates to the 1949 Philadelphia National Convention of the American Legion. Those two representative bodies are composed of the elected representatives of our membership. They have given to me the program on which the American Legion is operating. They have directed that I express their opposition to measures such as H. R. 5182, a proposal which would dismember the Veterans' Administration.

It has become customary to say that civilization is on trial. We know that before the body of world opinion there is no nation upon

which such a heavy burden of responsibility has been placed as our own. There is no other place for civilized men to turn from the thwarted field of frustrated hope. Spiritually and materially we must lead civilized people into a new field where peace may dwell and where the vision of freemen may be restored.

In such a situation it is well that our Nation should be strong internally. We must do nothing to weaken the faith of those 19,000,000 veterans who, by their effort in war, made secure our position as a leader among nations. We must continue to care for the disabled and his dependents. Else we shall break faith with them who died.

For the record let me go back as far as 1940. Let me retrace the thinking that then governed the question of providing hospitalization for our veteran population. At that time the 10-year hospital construction program, proposed by the Federal Board of Hospitalization, and approved in principle by the President, was given effect. Had not World War II disrupted this program, as it did every other phase of our lives, we should have had by 1949, 100,000 VA hospital beds, or 1 bed for each 40 veterans.

In 1941, the Milwaukee convention of the American Legion called for an inspired medical and hospital service in the Veterans' Administration to the end that the advancement and progress in medicine and surgery should be reflected in the Veterans' Administration so that veterans should have the best that science has to offer for their cure and treatment.

Later the Congress indicated its awareness of the medical and hospital problems arising out of World War II. With the passage of the Servicemen's Readjustment Act of 1944, the Veterans' Administration was directed to proceed and expedite the construction of additional hospital facilities. This construction program was prepared by the Veterans' Administration and the Federal Board of Hospitalization, approved by the Bureau of the Budget and the President, and authorized with appropriations or contract authority by the Congress. Had this program proceeded to completion the VA eventually would have 145,000 beds—an estimated ratio of 1 one to each group of 124 veterans.

Then somehow, some way, the decision was reached that too many beds were being provided too fast. Though Congress repeatedly had given its approval to the increase in the number of VA hospital beds, there came the dread cut-back of 16,000 beds, with which I know you are all familiar. Now we are told that an inflexible ceiling of 131,000 beds has been placed upon the Veterans' Administration. The clear, cold meaning of that decision is that the approximately fivefold increase in the veteran population would have its needs met by adding 31,000 beds. We have seen nothing to indicate that was the intention of Congress.

The CHAIRMAN. Was what is discussed in that last paragraph about the cut-back done following the filing of this Hoover study?

Mr. CRAIG. It was not, Mr. Chairman. As I recall, that comes before. I am stating from my memory. Now Congress has passed a law which makes it discretionary with the President as to when the additional 16,000 beds that have heretofore been allocated could be built.

In our search for the reasoning that led to such a decision we turned to the reports of the Commission on Organization of the Executive Branch of the Government. In that Commission's Report No. 16, Medical Activities, page 6, we find the following statement:

> However, after our task force's report was made public, the President altered the Veterans' Administration construction program by canceling authorization for 24 hospitals with an aggregate capacity of 11,000 beds, and reduced the size of 14 additional hospitals by an aggregate of about 5,000 beds. * * * This will be done without reducing the quality and extent of medical service to veterans.

The Commission on Organization of the Executive Branch of the Government now has passed out of existence. Within a short time after its final report was submitted to the Congress, the Commission became a part of history. Thus there was no official remainng group to which you could go, in the American tradition, to discuss the faulty reasoning, the errors in the task force survey reports, the unsympathetic manner in which the Commission's reports had been compiled. It is our belief that you could take that statement of the Commission, that 16,000 beds could be taken from the veterans without reducing the quality and extent of medical service to the veterans, as the key to the whole philosophy of the Hoover Commission, in its dealing with the problem of veterans' affairs.

In effect the Hoover Commission told Congress that it must accept all of the Hoover Commission recommendations as a package. "It is necessary," the Commission stated, "that the President and the Congress give careful attention to treating the whole body of our recommendations." That, in effect, calls upon the Congress to surrender its legislative powers to a no-longer-existent body, created in the first place to make a report to the Congress. In such a manner the constitutional right of petition would be denied those citizens who dare to question any one of the manifestly difficult technical questions upon which the Commission reported.

To replace and to continue the plans of the Hoover Commission there has developed the Citizens Committee for the Hoover Reports. This is a Nation-wide organization with headquarters in Philadelphia, New York, and Washington. It has the support of the Tax Foundation, the Chamber of Commerce of the United States, and the United States Junior Chamber of Commerce. And the money contributed to the Citizens Committee may be deducted for income-tax purposes, so the Citizens Committee announces.

I want to say here we have nothing but the highest and greatest respect for any one of the organizations that I named. We are all trying to do the same thing, to bring about greater economy and efficiency. We are simply approaching it from a different angle, based upon our experience.

Mr. HOLIFIELD. May I ask a question at this point?

Commander Craig, I would like to refer to your first paragraph on page 4. "In effect, the Hoover Commission told Congress that it must accept all the Hoover Commission recommendations as a package," and then you give a quote there. "It is necessary that the President and the Congress treat the whole body of our recommendations."

It seems to me that you burden the quote because the act of treating, considering the body as a whole, is almost necessary because of its interrelating recommendations. In other words, they are not all

separate recommendations. One recommendation has to do with other recommendations. It seems to me that it is necessary that Congress should consider the whole thing. I do not mean to say that it should accept the whole thing, you understand, but the consideration of it certainly as a whole is in order. I do not believe that you are on quite firm ground when you say that it calls upon Congress to surrender its legislative powers. It does not. The consideration of these matters clearly gives Congress the right to accept or reject, and therefore the consideration of these recommendations in itself does not mean the abdication of legislative power.

Mr. CRAIG. Of course you have abdicated no legislative powers, and we are asking you not only in this piece of legislation but the various committees to winnow out and to go over meticulously the suggestions that have been made. I think that probably what colors my statement or colors my mind was, first, the recommendation of this portion of the report as it has been followed by its advocates, the Citizens Committee, that say that you weaken it when you question any part of it.

Mr. HOLIFIELD. I am sure this committee does not take that position.

Mr. CRAIG. I think probably that is what stimulated my statement here, and that condition, Mr. Congressman, does exist in the country today.

Mr. HOLIFIELD. It may exist in the country, but I do not believe that it exists in this committee.

Mr. CRAIG. I am confident that is true.

Mr. HOLIFIELD. We are going to consider all these plans on the merits involved, and I do believe that the less use of heat and the more use of light on the part of the veterans organizations on this particular subject would be of benefit to the committee because we do want to discuss this thing on its merits.

Mr. CRAIG. That is our sole purpose in being here.

The CHAIRMAN. These very hearings themselves give any one in this Nation a chance to be heard upon the matter. It shows that we are going to explore all the recommendations in the light of public opinion, in the light of public experience, professional experience, and so forth. You can rely on it that we are going to do that job.

Mr. CRAIG. The American Legion has had no thought to the contrary. We only state what others have stated in their treatment of the subject. We know and fully realize, Mr. Chairman, that this committee and other congressional committees will carefully go into each matter presented.

Mr. HOFFMAN. Mr. Chairman, I would prefer very much that the witness be permitted to complete his statement, but in view of the fact that Mr. Holifield has asked that one question on that one single point, I would like to ask the witness a question.

Mr. Craig, on page 4 you state:

> In effect the Hoover Commission told Congress that it must accept all of the Hoover Commission recommendations as a package.

That is the same point that Mr. Holifield brought up. That is an accurate statement, is it?

Mr. CRAIG. I believe it is, Mr. Hoffman.

Mr. HOFFMAN. Where is the evidence in anything that the Hoover Commission ever wrote which states that we must accept the whole of it?

Mr. CRAIG. It doesn't say that you must accept the whole of it.

Mr. HOFFMAN. Where does it say that we should?

Mr. CRAIG. If you will permit me, I will read it.

Mr. HOFFMAN. It is the next sentence, I assume.

Mr. CRAIG. That is correct.

Mr. HOFFMAN. I differ with you.

Mr. CRAIG. A difference of opinion, possibly, Mr. Congressman.

Mr. HOFFMAN. I guess so because all the Hoover Commission said is, "It is necessary that the President and the Congress give careful attention to treating the whole body of our recommendations." All that can mean to the man of ordinary understanding is that we should look at all of it. It cannot be construed, at least in my opinion, as saying that we have got to take all of it. Personally, I do not propose to take some of the things in that Commissions report because I do not believe they are sound and I do not think that statement is justified at all.

Mr. CRAIG. We differ as to opinion.

Mr. HOFFMAN. You cannot produce a word of testimony, can you, that says that we have to take the whole thing?

Mr. CRAIG. I cannot produce anything other than what I have stated, Mr. Congressman, and that is this: I stated that probably what colored my mind and opinion in this matter was based on this statement, the proponents of the entire Hoover Commission report have used the propaganda that if you question any portion of the report, you weaken the possibility of adopting any part of it. That has colored my views in the matter, Mr. Congressman.

Mr. HOFFMAN. So far as I have been able to learn, since the Hoover Commission's report came out, the people generally because it has been advertised as a move to give us economy and efficiency, which they want, have asked that we put through, you might say, the Hoover report, that is, the people have. But never yet so far as I have been able to learn have we proposed to do a single thing recommended by the Commission that somebody has not come in and said with reference to that particular thing, "Don't do it."

Mr. ROOSEVELT. Will the gentleman yield for a minute? I would like to point out that one of the organizations that you state here, Commander, is the Chamber of Commerce of the United States, and on two separate reorganization reports, although they are in favor of the Hoover reports as a whole, the chamber has come in objecting to specific recommendations. I think this is a slightly exaggerated point. I do not think it has much bearing on the bill that we are considering now.

Mr. CRAIG. The only reason I point it out is to show that there are worth-while organizations in this country that take an opposing view. The only thing we are trying to do here is to get it right. If our experience and our honest beliefs did not manifest the statements that will be made to this committee today, we wouldn't make them because we are as sincere as the committee is in a desire to arrive at the truth.

Mr. RICH. Mr. Craig, in the various branches of the veterans affairs don't we find certain veterans organizations that are for one thing and certain others that oppose certain things that are presented to Congress? If we do not have differences of opinion, we are never going to iron them out——

Mr. CRAIG. That is what makes this country.

Mr. RICH. To a satisfactory conclusion on what is the best thing. What I might think would be best, you would probably differ in some things. That is the same thing in various branches. I find it in the veterans affairs because I have taken matters up with the veterans affairs to try to find out what was the right thing to do, when I had other branches of the veterans organization that were entirely different in their views. So the only way that we can come to a satisfactory conclusion is to listen to each and every one of them and then try to form an opinion.

The CHAIRMAN. I am going to suggest to the subcommittee that we refrain from interrupting the witness until he has completed his statement.

Mr. RICH. I think we ironed out a good point here. I think we all agree.

The CHAIRMAN. We did.

Mr. CRAIG. Having placed before you that background for the proposed legislation of H. R. 5182, as it is viewed by the American Legion, I should like to pass now to a discussion of the various provisions of that proposed legislation.

As we proceed with the consideration of H. R. 5182, please keep in mind that the Legion disbelief in the merits of the Hoover Commission recommendations affecting veterans' benefits is that such recommendations call for dismemberment of the Veterans' Administration.

You are called upon to accept a program of recommendations that would destroy the purposes of the Veterans' Administration, an independent agency which you created after bitter experience, gained in the administration of the whole program of veterans' benefits through separate and unrelated agencies, had demonstrated the unwisdom of such a course.

In place of the one unified agency, the Veterans' Administration, you would be asked to experiment with a new United Medical Administration, with a new veterans' insurance program corporation, with the veterans' home loan guaranty program in still another agency, with the Veterans' Administration hospital construction program in an untried agency, and with the remaining shell of the Veterans' Administration that would be left as a certifying authority.

Thus here you would have not one, but five agencies handling veterans' benefit programs. As Members of Congress you now have a large volume of correspondence dealing with questions raised by your constituent veterans. You can secure the information you need to handle such correspondence by reference to the VA. Can you visualize what would be your experience were you called upon to deal with five different agencies in securing the answers necessary for this type of correspondence?

I am emphasizing this matter of the dismemberment of the Veterans' Administration since H. R. 5182 is the measure that gives effect to

such dismemberment. The medical and hospital program of the Veterans' Administration is the key point in that organization. The Veterans' Administration, with a few exceptions, is built around the hospital and medical program. Take that out of the VA, and the remaining structure is greatly weakened.

The Citizens Committee for the Hoover Report has acknowledged the correctness of the Legion's statement that acceptance of the Hoover Commission recommendations would mean dismemberment of the Veterans' Administration. In a statement sent to the American Legion in January 1950, the Citizens Committee stated:

> The actual operation of hospitals would be performed on a service basis by the United Medical Administration. To some extent, this is an actual dismemberment of the Veterans' Administration.

In its "white paper No. 1" the Citizens Committee has the following comment about the proposal to place the hospital and medical program in the United Administration; hospital construction in a second agency; veterans' insurance in a separate corporation; the home loan guaranty program in a fourth agency; and make the remaining VA a certifying agency.

> Of the five dismemberment actions listed above, two do not involve any dismemberment * * *. This means that the five dismembering actions become three.

We differ with the Citizens Committee on two, therefore.

The Citizens Committee originally admitted that creation of the United Medical Administration would be one dismembering action. Later, in its white paper it admitted there would be three dismembering actions. That is more than a tacit admission of the correctness of the Legion's position.

I assure you members of the committee that it is not my purpose to ask you to act as umpires in the question of our differences with the Hoover Commission and with the Citizens Commitee. However, I feel that it is necessary to emphasize the part the Hoover Commission had, and the line of its reasoning, in providing the means of requesting the introduction of H. R. 5182 for your consideration.

Again we find the Citizens Committee, in its "white paper No. 1," quoting from the medical activities report of the Hoover Commission, as follows:

> * * * On June 30, 1948, there were only 155,000 patients in Government hospitals having a capacity of 255,000. Yet, despite the President's recent action reducing its building program by 16,000 beds, the Veterans' Administration alone is planning or has already contracted for 38,000 additional beds, of which 15,000 are under contract.

That statement implies that the Veterans' Administration was responsible for a hospital bed vacancy of 100,000 beds.

As of June 29, 1948, the Veterans' Administration had 102,238 beds. At that time there were 91,737 patients in these VA hospitals.

Currently, the Veterans' Administration has 114,110 beds with 99,541 patients. You see how inaccurate is the implication that the Veterans' Administration could ever have had 100,000 vacant hospital beds.

Mr. RICH. May I ask you, where did you get those statistics?

Mr. CRAIG. We have two means of information, Mr. Rich. We get them from Veterans' Administration figures, and we get them from

our field force that we maintain that constantly inspects veterans' hospitals.

Mr. RICH. Could you not make a request of all the hospitals as of a certain date the number of people in it and have it completely accurate of an inventory made for any particular day? Could that not be accomplished?

Mr. CRAIG. I think that could be done.

Mr. RICH. That could be done from their hospital records. Did you have such an inventory made?

Mr. CRAIG. As of this day the Veterans' Administration gave us that figure.

Mr. RICH. I was wondering how you got that.

Mr. CRAIG. We have two means.

To indicate further the inaccuracy of such a statement—the Citizens Committee for the Hoover Report still is using in its propaganda—there were approximately 29,000 eligible veterans unable to secure VA hospitalization at the end of February 1950. This was due to the shortage of beds in the Veterans' Administration hospitals.

Mr. LANHAM. May I ask a question there? Do you mean, is that veterans with a service-connected disability or veterans who simply need hospitalization?

Mr. CRAIG. Mr. Congressman, you can't tell. Here is the reason why you can't tell. Until a man has been examined, until a man has had his examination checked with his clinical and medical history at the time he entered the service, and until it has been adjudicated, you cannot say whether it is or it is not service-connected.

Mr. LANHAM. You can say whether or not at the time he makes application for hospitalization he has been given service-connection. That is the point. Can you tell us how many of these veterans who are waiting for hospitalization are definitely service-connected or have been determined to be service-connected at the time?

Mr. CRAIG. I cannot; no, sir.

Mr. LANHAM. The reason I ask that question is, as I understand it, Congress has never definitely fixed the policy as to whether or not it is going to guarantee hospital treatment for veterans without service-connection. I do not know what the policy should be, but the Congress ought to adopt a policy one way or the other.

Mr. CRAIG. Your policy now, Mr. Lanham, is that a veteran makes a statement as to inability to pay before being admitted into the hospital. You sign Form P–10.

Mr. ROOSEVELT. For non-service-connected disability.

Mr. CRAIG. That is correct.

Mr. ROOSEVELT. Could I ask a question here? I do not quite get the correlation between the apparent vacancies of about 15,000 beds at the bottom of page 6. Currently the VA has 114,000 beds and 99,000 patients. That is 14,500 vacant beds. Then at the top of page 7 you say the Citizens Committee is stating that there are 29,000 veterans who are unable to get into VA hospitals? In other words, the Citizens Committee, in view of a 15,000 vacancy, is saying that there are 29,000 veterans who should but cannot get in.

Mr. CRAIG. That is the record of veterans waiting to be hospitalized by the Veterans' Administration. I can give you the waiting list.

The CHAIRMAN. Will you proceed, and then we will call on you for the comments.

Mr. LANHAM. I beg your pardon, Mr. Craig. I did not know you had asked to finish.

Mr. CRAIG. I am at the will of the committee, whatever you gentlemen care to do.

The CHAIRMAN. Will you proceed?

Mr. CRAIG. The Commission statement quoted above does not indicate that the vacant beds were in military hospitals constructed for the casualties of war; that many of these hospitals had been deactivated or abandoned because of the successful ending of hostilities and the demobilization of the armed forces; does not tell you that those vacant beds were not under the control of the Veterans' Administration. Thus was forged another link in the chain of propaganda to pave the way for requesting your consideration of H. R. 5182.

This proposed legislation had its genesis in the Medical Activities Report of the Committee on Organization of the Executive Branch of the Government. As I studied that report I was surprised to learn that a vote in favor of its adoption was secured. A majority of the members of the Commission expressed dissent, or abstained from consideration. I do not understand how you members of this committee of Congress would be expected to arrive at an approving decision on H. R. 5182, after studying those dissenting opinions of the members of the Hoover Commission.

With the thought that you may have not read them recently, let me comment briefly with regard to those dissents.

Messrs. Charles Aiken and Louis Koenig discussed this phase of the Commission's activities in material published in the October 1949 issue of the Political Science Review. These former members of the Hoover Commission staff said:

> Its (the Commission's) writings curl with dissents. For every Commissioner, at some point in the reports, utilized the dissent or the separate opinion. Even more indicative of the Commission's continual argumentative mood is the existence of numerous and at times acrid, dissents voiced by Commission majorities.

The Medical Activities Report, out of which came H. R. 5182, is a case in point.

Commissioner James Forrestal, in view of his then position as Secretary of Defense, abstained from the consideration and preparation of this report. You know, of course, that Dr. Meiling, the Medical Director of the Department of Defense, has indicated in statements made to the House Armed Services Committee, that the Department of Defense feels its compulsion to maintain a separate medical and hospital service, contrary to the provisions of H. R. 5182.

Chairman Hoover and Commissioner Manasco dissented from the Medical Activities Report on the ground of the administrative procedure such a report would establish.

Commissioner Brown dissented since he believes the armed forces should maintain their own medical and hospital services.

In their dissent to the proposal that the United States Public Health Service be abolished in favor of United Medical Administration, Vice Chairman Acheson, Commissioners Aiken and Rowe expressed a view-

point that would be applicable to the Veterans' Administration. In their dissent they said:

> In our opinion the proposal to create an independent agency for those hospital activities violates two of these basic principles which were approved by the full Commission in that report (General Management and the Executive Branch, p. 34).
>
> 1. Government agencies should be grouped into departments according to major purposes.

I call your attention to the fact that the Veterans' Administration as presently constituted, fulfills that purpose.

> 2. Government agencies should be consolidated into about one-third of the present number.

I call your attention to the fact that dismemberment of the Veterans' Administration through the enactment of H. R. 5182 would make five agencies out of one existing agency.

That is an error. It would create one so far as this bill goes, but as far as the over-all recommendations extend, it would make five.

Mr. RICH. Did I not understand previous to this time you stated here in the statement that there would be three?

Mr. CRAIG. The Citizens Committee say three; the Legion says five.

Further, in expressing their dissent, these three members of the Commission made another statement that would apply with equal force to comments regarding the effect of the Hoover Commission recommendations on the Veterans' Administration.

I quote:

> In the face of this situation, the creation of another independent agency can only be justified by most extraordinary circumstances. We can find no such compelling reasons here. Nor have the majority stated such reasons.

Commissioner Pollock, in a separate opinion, said of the proposed United Medical Administration:

> Under such an arrangement, the Military Establishment could invariably muster a majority to determine policies affecting not only all of the hospitals in the consolidated service but all of the present functions of the Public Health Service including preventive medicine and research, as well as of the Food and Drug Administration.

Gentlemen, Commissioner Pollock was prophetic; he spoke with clarity and wisdom. For H. R. 5182 does all that Commissioner Pollock said it would and more. It completely abolishes the Public Health Service.

I call your attention to the fact that the Citizens Committee for the Hoover report, in its publicity handbook, has told its supporters:

> Do not attribute assertions about dollar savings directly to the Hoover Commission. Remember that the official Commission report did not contain any specific estimate of savings.

I think that advice of the Citizens Committee applies directly to the proposal, contained in H. R. 5182, to create the new, untried, experimental United Medical Administration. There is nothing in H. R. 5182 to indicate there will be economy in operation of such an agency.

Equally, on the score of lack of increased efficiency, with regard to H. R. 5182, may I call your attention to the fact that the Veterans' Administration now has, in one place, the basic records of the veteran

population, insofar as they apply to the administration of veterans' benefit programs. Were H. R. 5182 to be approved, then one of two things probably would occur. You would either divide the existing records between the shell remaining of the Veterans' Administration and the new experimental United Medical Administration; or you would duplicate the existing records with all of the delay that would entail. Therefore, I submit there is neither economy nor efficiency in the proposal to enact H. R. 5182.

I can see no reason for engaging in such a gigantic experiment as the United Medical Administration appears to be. The Department of Medicine and Surgery in the Veterans' Administration has risen to high eminence in regard to its medical and hospital services. This is accepted by the Hoover Commission itself. The reports of the Commission indicate that the type of medicine and surgery now practiced in the VA would form the pattern for the proposed United Medical Administration.

The Veterans' Administration has by far the largest number of hospital beds and patients and personnel of all the Federal agencies considered. Decades of hard work have been necessary to bring the medical services to this high state of efficiency. Why scrap such an agency in favor of an untried experiment?

I can see no economy in the proposed United Medical Administration. Any economy that would accrue would be the result of reduced services to the veterans. Parenthetically, may I say that the reduction of services to the veterans of our Nation is the underlying reason for this proposal of the United Medical Administration. Such an opinion is based upon the effectively ingenious manner in which the Commission has asked Congress to do what it has done numberless times before, to define the class of beneficiaries who shall be treated in the VA hospitals.

Under the proposed UMA there would still need to be the Veterans' Administration and veterans to be cared for, though H. R. 5182 makes no provision for such care. It could be presumed that VA would have a medical certifying agency, though the experience of the Federal Government in dealing with certifying agencies handling veterans' benefit programs has not been a happy one. However, we fail to find such a provision in the bill H. R. 5182. All we can see is the total abolition of the medical service of the VA.

Under the proposed UMA the Military Establishment will still have its own medical agency.

It may be, and perhaps it is likely that, in asking you to approve the proposed United Medical Administration, the Commission has desired to add another agency to those already in existence. Instead of economy such a move would prevent additional bills of expense to the Federal Government.

Instead of efficiency there probably would be a slowing of essential services to the veterans. I fear that the Congress' will, as expressed in the program of veterans' benefits, would be thwarted in the type of administration that would come into being.

Along with the Congress, the American Legion is firmly of the belief that the cost of caring for our disabled veterans is an integral part of the cost of war. The Nation has this obligation to pay for the cost of caring for disabled veterans just as clearly and just as convincingly as it has to lay the cash on the barrel head to produce the guns and

ships and tanks and planes needed to wage a victorious war. When the size of the war increases, the number of soldiers increases. Obviously, the number of veterans increases and the cost of the care of the disabled among them is in direct proportion to that increase in number of soldiers, sailors, and others. You just cannot separate the other costs of war one from another. Why try to do it in the case of the disabled veterans?

I think it is fair to ask why somebody on the outside should come in and upset Congress' will. Such a thing is beyond my power of comprehension.

Congress has an unwritten pact with the veterans of our Nation. As it is now, Congress can say to the veteran: This man has been promised. This has been done. This is working. Why disturb a program that in the main is functioning satisfactorily? Why dismember an agency that has proved itself in practice to experiment with a new and untried agency that appears futile in peace, impossible in war.

I will try to answer any question. If I do not have the answer, if I may be permitted to confer with our experts in the relative fields here I will gain the information.

Mr. HOLIFIELD. I would like to refer to page 6 of the Commander's statement, where you quote the medical activities report of the Hoover Commission at the bottom of the page, which clearly shows the capacity of Government hospitals at 255,000 beds and the occupancy as only 155,000. It seems to me that you burden your statement when you go ahead and try to apply a statement which clearly refers to the total over-all Government hospitals. You refer to that and take the onus on the Veterans' Administration for the meaning of that statement.

In other words, I think you are drawing a meaning out of the medical activities report or the interpretation of it by the Citizens Committee which certainly does not exist in the text that you have used as the proof of your contention.

As a matter of fact, I think the records will show that there is a surplus of approximately 100,000 beds in Government hospitals. That includes veterans, of course, and the branches of the active service. I am not contending for the contention of the United States Medical Report, but there is a condition there of surplusage on the one hand and inadequacy on the other. I have been working on that in my own California district where we have been trying to get the Administrator of the Veterans' Administration to take over, namely, the Long Beach Naval Hospital which is being deactivated, and the McCormack Naval Hospital which is being deactivated.

Mr. CRAIG. And the Corona.

Mr. HOLIFIELD. And the Corona Naval Hospital. There is no denying the fact that there is a surplus of beds in those facilities, while Birmingham and Sawtelle are overcrowded and have a waiting list. We may have a condition here that needs correcting. As to the method of correcting the situation I can certainly see some strength to your argument. Do we want the tail to wag the dog or the dog to wag the tail? That is the question. Why should the Veterans' Administration, for instance, be building additional hospitals for this deficiency which most of us admit exists, while these military hospitals are being deacti-

vated? We have approached the administrator on this problem for our own southern California area.

Mr. CRAIG. So have we, incidentally.

Mr. HOLIFIELD. I know you have. We have worked with the American Legion on this. Maybe the approach of this bill is wrong. Maybe we are going at it the wrong way. As long as the hospitalization problem of veterans and service men is an obligation of the National Government and it is a similar service, whether it be for the soldier or sailor who is now in the service or whether it be for the veteran who is out of the service, and while the bulk of the obligation is in the Veterans' Administration and proportionately the smaller amount at the present time is in the armed services, maybe we are going at this thing the wrong way. Maybe the Veterans' Administration should be given the facilities which exist in the military services and, under contract or some other arrangement, have a section of the hospital set aside for the treatment of active military personnel. Maybe that is the solution. I do not know. What would you think of that type of arrangement in order to cure this over-all surplusage on the one hand and deficiency on the other?

Mr. CRAIG. We have analyzed that carefully, and if you will permit me, I will give you our findings on it.

First of all, there is a surplus of hospital beds in the United States that cannot be staffed. A hospital bed, as I use the term, is only a bed that can be attended by a doctor, nurse, technicians, and employees to keep and treat a sick man or woman in it. Now the time has come, because of our shortage of doctors in the United States—we are graduating only 6,000 a year, and practically 3,500 are leaving the profession annually—that you do not take the doctor to the hospital any more, but you take the hospital to the doctor. Back to the days of General Bradley, you have been building your Veterans' Administration hospitals in the large medical centers, where they can be staffed, where Drs. Mayo and Rowntree, who will appear before you, have helped to inject private medicine through the dean's committee of putting in residences, and postgraduate schools where private medicine contributes to public medicine through the medium of our medical centers.

Many of these 100,000 beds which we toss around in our mind are beds that were built out in the sticks, in the forks of the creek where the troops were during the war. You cannot take doctors out to them to staff them. I know that you can run over in your own mind many Army and Navy hospitals built in the rural areas of the South and in the rural areas of the North, such as Camp McCoy up in Wisconsin and you can think of many. The beds are there, the roof is there, and the walls are there, and you can fire the furnace; but you couldn't have any doctors there because we don't have that many in the United States. So when you speak of this 100,000 beds you are speaking in a great number of cases, Mr. Congressman, of beds that you could not get doctors for.

Mr. HOLIFIELD. I realize that fact exists. Do you have any over-all figures to show us the number of effective beds? I use your term "effective" because I agree with you in your interpretation of a hospital bed. The physical bed means absolutely nothing. Too often in these reports I have found them using the number of physical beds

when they had no attendant nurses or doctors. So, let us see if we do have any over-all figure of effective hospital beds.

Mr. CRAIG. In the Veterans' Administration or in the Nation?

Mr. HOLIFIELD. In the Nation.

Mr. ROOSEVELT. In the armed services first. Let us break it down.

Mr. HOLIFIELD. I am saying in the Government hospitals. That would include Army, Navy, Air Force, Coast Guard, and United States Public Health.

Mr. ROOSEVELT. How many effective surplus beds are there in the armed forces first?

Mr. CRAIG. I can't answer your question.

Mr. HOLIFIELD. We know from observation there are many because they are deactivating a lot of these military hospitals.

Mr. CRAIG. I can only give you the statement that I received from the Secretary of Defense, and I presume you have heard him speak on the matter himself. We are for and encourage the relinquishing by the armed forces of hospitals to the Veterans' Administration to curtail building if the beds turned over could be staffed, and make the saving to cut down additional hospital costs. Make no mistake about that, gentlemen. The question is, where are they? You mentioned two out there. It has been our contention that those two hospitals could be staffed because they are close to the medical center of Los Angeles.

Mr. RICH. How about Valley Forge?

Mr. CRAIG. Valley Forge?

Mr. RICH. In Pennsylvania.

Dr. HYMAN D. CHAPIRO (chief medical consultant, national rehabilitation commission, the American Legion). We have gone on record stating it can be staffed.

Mr. RICH. If you staff that hospital, it would then relieve us of the obligation to furnish new equipment for 1,200 patients that we could utilize.

Dr. SHAPIRO. That is correct.

Mr. RICH. I am glad to hear that.

Mr. HOLIFIELD. Can you respond to my question, Commander, of the over-all surplusage of effective hospital beds?

Mr. CRAIG. This is hearsay from Dr. Meiling. There are currently 11 Army general hospitals and 24 naval hospitals in the continental United States. These hospitals have a construction capacity, based on 8-foot centers, or 100 square feet per patient, or 41,276 beds. This provides an expansion factor of 72 square feet per patient on the so-called 6-foot center, or 51,654 beds. The patient load in these 35 hospitals amounted to 14,594 military personnel, 5,194 Veterans' Administration beneficiaries, and 3,685 others, or a total of 23,473. At the present time I do not have available the constructive capacities of the Air Force hospitals, the Army station hospitals, or naval dispensaries. We are now making studies to develop these facts and figures. We have done our best to get it. We don't have it.

Mr. ROOSEVELT. Will the gentleman yield?

Mr. HOLIFIELD. Yes; I will yield, but let's have Public Health, too, for just a moment, just briefly.

Mr. CRAIG. Here is the Public Health. You have a total of construction capacity of 8,170, and they are full. I have a general statement here which I will pass around to you.

Mr. Holifield. You have given us the occupancy of roughly 43,000 and a possible 51,000, but an actual 41,000. Does that mean that the difference there is effective beds or nonstaffed beds?

Mr. Craig. No; it does not mean that, sir. What you want and what Mr. Roosevelt wants is to know how many staffed beds are vacant in the Military Establishment.

Mr. Roosevelt. Effective beds.

Mr. Craig. I can't give you that figure, but I want to make the general statement, not speaking for the Veterans' Administration, but we advise this committee that any one you have we would like to be made available to the Veterans' Administration.

Mr. Rich. Can you get that figure and have it inserted in the record?

Mr. Craig. We will go again to Dr. Meiling.

Mr. Holifield. I think the Secretary of Defense is the man who could supply that to the committee rather than Mr. Craig.

Mr. Craig. We will try to get it for you.

Mr. Roosevelt. I would like to inject a thought here. It seems to me that the medical services of the Army, Navy, and Air Force in time of peace should be to maintain a relatively efficient, perhaps quite considerably overstaffed medical branch of those three services, so that they can expand in time of national emergency or war. When you talk of an Army or Navy hospital being turned over to the VA, depending on whether the VA can then locate the doctors in that community to staff it, the technicians and the nurses, it seems to me the problem would be much better solved if the VA leased not just the physical hospital itself but had turned over to it by contract or otherwise the entire medical personnel. In other words, effective beds would be turned over, not just skeleton beds.

Mr. Craig. That is right.

Mr. Roosevelt. Then that way you would be both overcoming your shortage of doctors which you have referred to and at the same time you would be giving continual experience and training to the medical staffs of the armed forces.

Mr. Craig. I think we would go with you 100 percent on that.

Mr. Holifield. In other words, the figures that we seem to be dealing with here are approximately 100,000 veterans' cases and 23,000 military-service cases. I believe a case can be made for economy in combining the function of Government hospitalization. I believe a case can be made if there is not something very important that would be more objectionable on another basis, but it would seem to me that the combining should be the other way rather than turning the Veterans' Administration beds of 100,000 over to the 20,000. In other words, if the Veterans' Administration has proven that it is economical from the over-all national interest, economy, and efficiency to combine governmental hospitalization, why couldn't the present condition be reversed whereby you are at the present time contracting with the military forces to take your overflow in some hospitals? Why could not the Veterans' Administration be contracted with by the military to have a ward or a section of a hospital devoted to peacetime military personnel hospitalization?

Mr. Craig. I think you are going to hear some other objections. This is taking me into a field with which I am not familiar, not being a doctor. I will mention it to open the subject for your thinking.

There are three different kinds of medicine that you are dealing with. Your public-health medicine is preventive medicine. It deals with the research and the prevention of areas of infection that affect the public. Then you get to military medicine, which is on-the-spot curative or palliative medicine. That is, medicine that is trained and created to take care of a rapid influx of casualties. Then you have Veterans' Administration medicine, which is about the same as private medicine. It is a convalescent medicine. At the same time, it is curative. Here, if you wadded these three together, you would be attempting to mix them together when they are entirely different and separate, so the medical people advise me, and they are here to tell you their own story.

Mr. HOLIFIELD. I hope we will have that point developed.

Mr. CRAIG. It will be, sir.

Mr. HOFFMAN. Mr. Craig, is it not true that almost all Members of Congress either served in some war or had blood relatives who did?

Mr. CRAIG. Undoubtedly that is true. I don't know it in terms of figures.

Mr. HOFFMAN. Just as a general proposition.

Mr. CRAIG. I would think so.

Mr. HOFFMAN. You would agree with me—would you not—that the Members of Congress as a group and individually are all sympathetic toward veterans and, if they make an error, want to make it on the side which will benefit the veterans.

Mr. CRAIG. That is true; yes, sir.

Mr. HOFFMAN. Also, you will agree with me that the veterans' organizations are very, very powerful politically.

Mr. CRAIG. I would not agree with that statement.

Mr. HOFFMAN. You will not?

Mr. CRAIG. I will not.

Mr. HOFFMAN. Do you speak advisedly?

Mr. CRAIG. I speak advisedly.

Mr. HOFFMAN. And sincerely, of course.

Mr. CRAIG. I don't know of any veterans' organization that ever took part in party politics.

Mr. HOFFMAN. I didn't say politics, did I?

Mr. CRAIG. What do you mean when you say "politically"?

Mr. HOFFMAN. I mean just exactly what the word means.

Mr. CRAIG. What does it mean, then?

Mr. HOFFMAN. If we want to narrow it down, I mean in the election of Members to Congress who the Veterans' Administration thinks will be sympathetic toward veterans and their needs.

Mr. CRAIG. I never have known of an organized group of any denomination in the United States that took upon itself such a burden, nor have I ever known—I will be very frank with you—veterans as a group voting as a group. It always has been my observation that they split down along party lines the same as farmers and lawyers do.

Mr. HOFFMAN. I think that may be true, but for specific measures they exert political power. Wait until I ask my question, so we shall know what we are doing. I say, Will you not agree that veterans advocate the election of those Members who they think are sympathetic toward veterans?

Mr. CRAIG. The American Legion never has.

Mr. LANHAM. What about your——

Mr. HOFFMAN. Pardon me.

Mr. LANHAM. I want to add to what you say. I want to implement what you say. What did the American Legion mean by sending down the word to the boys "to put on their brass knuckles"?

Mr. HOFFMAN. That is what I wanted to ask him. That is what I wanted to know.

Mr. CRAIG. Has the question been propounded?

Mr. HOFFMAN. His question is the same as mine. You put out a circular and you told your members, or the Legion did—when I say "you," I mean the Legion—"to come out fighting, to come out with brass knucks," after you had told them to contact their Congressmen and their Senators; did you not?

Mr. CRAIG. You mean have we told them to contact their Congressmen and Senators?

Mr. HOFFMAN. Yes.

Mr. CRAIG. Absolutely; yes.

Mr. HOFFMAN. And to come out with brass knucks; did you not?

Mr. CRAIG. Not as you are giving the inflection to the term; no.

Mr. HOFFMAN. Wait. "Brass knucks" were the words you used.

Mr. CRAIG. That is right.

Mr. HOFFMAN. Do you mean to say to me that you were not exerting political pressure, this being an election year, when you made that statement?

Mr. CRAIG. I mean exactly that, Mr. Hoffman. Just a minute, please, sir. If permitted to make one statement, let me put this firmly in the record. The American Legion approaches this problem in all humility, with the final and avid desire to arrive at the truth. If we are right, we expect the Congress to give credence to our statements. If we are wrong, we do not expect them to. We have no selfish interest in this matter whatsoever, and we are only simply trying to aid the Congress in solving or assisting in solving one of the biggest social problems confronting this Nation today. I will agree with you that the term "brass knucks" is an unfortunate statement; and, as you put it to me now, I do not approve it, but I will say that our only purpose in sitting around this table or any other table in the offices of the American Legion will never be to use political pressure of any kind.

Mr. HOFFMAN. I might say to you that along the same line, for example, I get postal cards—I assume because I introduced this bill—and because of statements which have gone out from the offices of veterans' organizations, more particularly the American Legion, which are in substance like this: "We elected you; we can kick you out, and we cannot understand why you are always against the veterans. Take time off to vote for legislation which will assist the veterans."

My answer to those is that you have the votes; anytime you do not like me you just find somebody else who will do a better job and it is all right with me, because that is the way it has to be.

I do not want any fight with the American Legion or any other organization, this being election year. You understand that; do you not? But I resent a statement such as "Come out at me with brass knucks."

Also, I wish to make this further statement, and I hold no brief for Mr. Hoover—he needs none from any of us—but in a cartoon he is depicted as wanting to shove the veteran in hospitals aside for some other Federal employee. I hope you do not condone that kind of

cartoon. Instead of intimidating me, it makes me ornery to receive that.

Mr. ROOSEVELT. That is a bad thing to do.

Mr. HOFFMAN. You resent that; everybody does. We do not like to get kicked around.

Mr. CRAIG. Nobody is trying to kick anybody around.

Mr. HOFFMAN. I am glad to know that, but I still feel the places where they kicked me.

Mr. CRAIG. I cannot speak about your own district in Michigan; but, when you say you get letters from veterans, you also get them from farmers and taxpayers in various categories.

Mr. HOFFMAN. I get them from pretty nearly everyone.

Mr. CRAIG. So, it is not the veteran alone who is complaining.

Mr. HOFFMAN. No; the CIO really hits me harder than the veteran. Now, to get back a little, on page 6 of your statement you say:

On June 30, 1948, there were only 155,000 patients in Government hospitals having a capacity of 255,000.

Is that correct?

Mr. CRAIG. That is the report we received from the task force. It is in the Hoover Commission report.

Mr. HOFFMAN. Then you say:

Yet, despite the President's recent action reducing its building program by 16,000 beds, the Veterans' Administration alone is planning or has already contracted for 38,000 additional beds, of which 15,000 are under contract.

That is accurate; is it not? Approximately so?

Mr. CRAIG. That is our best information; yes, sir.

Mr. HOFFMAN. I am leading to this point. I cannot understand this statement:

That statement implies that the Veterans' Administration was responsible for a hospital-bed vacancy of 100,000 beds.

Mr. CRAIG. Yes.

Mr. HOFFMAN. Now, it does not do any such thing; does it, Mr. Craig?

Mr. CRAIG. We do not think it does, but the other people have said it will.

Mr. HOFFMAN. Who are the other people?

Mr. CRAIG. Citizens Committee.

Mr. HOFFMAN. They have stated that the Veterans' Administration was responsible for a hospital-bed vacancy of 100,000 beds?

Mr. CRAIG. Yes.

Mr. HOFFMAN. No; the Citizens Committee did not say that the Veterans' Administration was responsible for a vacancy of 100,000 beds; did they?

Mr. CRAIG. Yes.

Mr. HOFFMAN. Where did they say it?

Mr. CRAIG. Failure to utilize capacity. This is the Commission on Organization of Medical Activity, March 1949.

Mr. HOFFMAN. That is not the Citizens Committee.

Mr. HARVEY. Is that a task-force report?

Mr. CRAIG. This is the Hoover Commission report:

While these great new construction programs are going forward, there is a large unused capacity in Federal hospitals. On June 30, 1948, there were only 155,000 patients in Government hospitals having a capacity of 225,000. Yet,

despite the President's recent action reducing its building program by 16,000 beds, the Veterans' Administration alone is planning or has already contracted for 38,000 additional beds, of which 15,000 are under contract.

Continuation of your present policies may lead to a hospital situation in 1980 with 300,000 beds for the Veterans' Administration alone. The armed forces plan an additional 5,000.

Mr. HOFFMAN. That does not say that the Hoover Commission says the excess beds are the result of the Veterans' Administration's policy, does it?

Mr. CRAIG. We just want to be clear with the committee that is not true. If we all agree that the Veterans' Administration is not so responsible, why then I suppose we have accomplished our mission.

Mr. HOFFMAN. I understand from your statement generally and from the literature you have put out that you charge the Hoover Commission is after the Veterans' Administration.

Mr. CRAIG. I do; yes.

Mr. HOFFMAN. All right. Now, you know why the Hoover Commission was created; do you not? Congress either could not or had not done the job of getting rid of this waste and extravagance that everybody is complaining about, including yourself. You are, too; are you not?

Mr. CRAIG. I am what?

Mr. HOFFMAN. You are complaining about the waste and extravagance in the Federal Government?

Mr. CRAIG. I suppose everyone is if it can be pared down. We all want to do it, of course.

Mr. HOFFMAN. Yes; except if it applies to ourselves.

Mr. CRAIG. I am not a beneficiary of the Government in any capacity.

Mr. HOFFMAN. Now, the Hoover Commission was created, as I understand it, Mr. Chairman, to do a job which neither the President nor the Congress had done. We had authority to do it; we just did not do it.

Now, do you know of anyone who is on that Commission or on the task force who, to use a common expression, had "an ax to grind"?

Mr. CRAIG. No; I do not think anybody had "an ax to grind."

Mr. HOFFMAN. Do you concede that they all acted from proper motives?

Mr. CRAIG. Good faith?

Mr. HOFFMAN. Yes.

Mr. CRAIG. One hundred percent; yes, sir.

Mr. HOFFMAN. Do you not think that any charge that they acted selfishly is wrong.

Mr. CRAIG. I have made no such charge.

Mr. HOFFMAN. I was not saying that?

Mr. CRAIG. I would not make such a charge.

Mr. HOFFMAN. So, if any mistakes were made by the Hoover Commission, they were of the head rather than the heart?

Mr. CRAIG. Absolutely.

Mr. HOFFMAN. You concede, too, that mistakes of that kind are almost certainly inevitable?

Mr. CRAIG. As long as we have human beings we are going to have mistakes.

Mr. HOFFMAN. And even the Legion representatives may be making some of these?

Mr. CRAIG. We have made lots of mistakes; we will make a lot more. We try to be right most of the time.

Mr. HOFFMAN. On page 8 you state:

> Chairman Hoover and Commissioner Manasco dissented to the medical activities report on the ground of the administrative procedure such a report would establish.

Is it not a matter of fact that they objected because they wanted this advisory board to have authority rather than merely advisory capacity?

Mr. CRAIG. That is one of their objections.

Mr. HOFFMAN. That is the objection?

Mr. CRAIG. Here is the entire dissent here.

Mr. HOFFMAN. That was the real objection; they wanted the board to have more power?

Mr. CRAIG. That is right.

Mr. HOFFMAN. It was not for the reason stated in the preceding paragraph; was it?

Mr. CRAIG. Now let us see. Your bill is advisory only as to its requirements. Where are you, Mr. Hoffman, please? You are on page 8; are you not?

Mr. HOFFMAN. Yes, page 8, the second paragraph.

Mr. CRAIG. Yes, sir, "on the ground of the administrative procedure such a report would establish." I interpret the difference, and it is a play on words of course, of whether or not this Board of Surgeons General would be advisory or would have the authority to bind the Administrator.

Mr. HOFFMAN. And Mr. Hoover and Mr. Manasco wanted them to have the authority; is that correct?

Mr. CRAIG. That is correct.

Mr. ROOSEVELT. But they did not disapprove of the pooling of the resources and facilities of all the medical services?

Mr. CRAIG. No. I used the word "administrative" for the purpose of tempering it.

Mr. HOFFMAN. On page 10, is this a fair statement:

> Parenthetically, may I say that the reduction of services to the veterans of our Nation is the underlying reason for this proposal of the United Medical Administration?

Mr. CRAIG. I sincerely believe in my own mind that there is a desire on the part of many of the proponents of this legislation to reach that exact result; yes sir.

Mr. HOFFMAN. That is, to give the veterans less?

Mr. CRAIG. I think so. That is my judgment; yes sir.

Mr. HOFFMAN. I do not know whether you heard my statement or not, but I introduced the bill because of the criticism that we were not doing anything about the Hoover Commission recommendations.

Mr. CRAIG. Yes; I heard your statement.

Mr. HOFFMAN. Their attorney drew these 11 bills, and I slapped them all in to get a start. Of course, you do not need to answer, as far as I am concerned, but now can you name any individual who you think wants to give the veterans less medical service than that to which they are entitled?

Mr. CRAIG. I did not say "less medical service"; did I?

Mr. HOFFMAN. What did you say?

Mr. ROOSEVELT. A "reduction."

Mr. CRAIG. A reduction of service.

Mr. HOFFMAN. If there is any difference between "reduction" and "less," I will take your word for it.

Mr. CRAIG. I think there are many.

Mr. HOFFMAN. Who want to give the veteran less?

Mr. CRAIG. Yes. There are a lot of people in this country who think the veteran has received too much.

Mr. HOFFMAN. Do you know of anybody or any organization that is out to give the veteran less medical service than he is getting or to which he is entitled?

Mr. ROOSEVELT. Was there any individual connected with the Hoover Commission report recommending it?

Mr. CRAIG. I do not think so, Mr. Roosevelt.

Mr. ROOSEVELT. To whom do you refer in this statement? You say "the underlying reason for this proposal" is "the reduction of services to the veterans of our Nation."

Mr. CRAIG. That is our judgment.

Mr. ROOSEVELT. Who has that "underlying reason"? That is what Mr. Hoffman and I would like to know. Who has that "underlying reason"?

Mr. RICH. As I understood it, it was Mr. Hoover and Mr. Manasco.

Mr. HOFFMAN. No; that is something else.

Mr. CRAIG. I think that Mr. Hoover and all of the other members of the Commission, I would like to make that very frank——

Mr. ROOSEVELT. Do you not have this "underlying reason"?

Mr. CRAIG. No.

Mr. ROOSEVELT. Who does have the "underlying reason"?

Mr. CRAIG. Mr. Roosevelt, I could not names names.

Mr. HOFFMAN. Could you name the class or group?

Mr. ROOSEVELT. Or organization?

Mr. BONNER. Do you not hear that spoken of often?

Mr. CRAIG. Yes.

Mr. BONNER. I do. In daily contacts with people I hear it generally stated that the veterans have been overindulged with.

Mr. ROOSEVELT. That usually refers to the "52–20 Club." He says here, "the underlying reason for the reduction of services to the veterans of the Nation." Now I assume that that refers to medical services.

Mr. HOFFMAN. It goes right along with that kind of cartoon that was printed.

Mr. CRAIG. That was the way we had to depict our judgment as to what this would do. The report of the Hoover Commission is that a patient is a patient. You may read that in the report if you care to.

Whether or not it was good for the American Legion to do it, I do not know, but we are in good faith in trying to depict to our own members, and those are the people to whom the communication went.

Mr. HOFFMAN. You will concede—will you not?—that people generally all want to favor the veteran, especially the disabled veteran?

Mr. ROOSEVELT. I just want to know whose underlying reason this is.

Mr. HOFFMAN. What is your answer to that?

Mr. CRAIG. I think that the vast majority of people want to see the disabled veteran taken care of.

Mr. HOFFMAN. And have a priority?

Mr. CRAIG. Yes.

Mr. HOFFMAN. And the Congress has given them many priorities?

Mr. CRAIG. Yes.

Mr. HOFFMAN. And many benefits?

Mr. CRAIG. That is right. Of course, there has always been the thought in the minds of many that the veteran should not be treated as a class. The Congress has never adopted that view.

Mr. HOFFMAN. I agree with Mr. Bonner that there are many people who say that the veterans have been getting and are getting too much.

Mr. CRAIG. That is the genesis of this statement.

Mr. HOFFMAN. Yes, and you do not want to give people any reason to have an intensified feeling of that kind; do you?

Mr. CRAIG. No, sir.

Mr. HOFFMAN. Is it not possible, if we continue to grant every benefit, every increase in compensation that not the veterans as a whole but someone speaking for them asks, that ultimately there will be created some ill will?

Mr. CRAIG. If the veterans or veterans' organizations ask for things that are unreasonable and inequitable, I think the result you forecast would occur.

Mr. HOFFMAN. There is a danger?

Mr. CRAIG. I think there is a danger.

Mr. HOFFMAN. And there are veterans just as there are people in every other group who think only of themselves?

Mr. CRAIG. That is right.

Mr. HOFFMAN. Just like Congressmen, we will say?

Mr. CRAIG. Certainly.

Mr. HOFFMAN. Was not your predecessor in office on the task force or at the head of it?

Mr. CRAIG. On insurance, Franklin D'Olier. He refused to serve on this committee.

Mr. RICH. With reference to the criticism that the veterans are getting too much, I do not know that I have ever heard anyone say that a service-connected veteran who needs hospitalization is getting too much.

Mr. BONNER. I do not think there is a separation of benefits in the minds of the general public. You hear this school program talked about. You see the advertisements in the papers here in the District of Columbia, and it is generally known by a lot of people that many of these schools are rackets. That brings on the criticism in itself.

Mr. RICH. We are talking primarily of hospitalization.

Mr. BONNER. Therefore, I go back to the statement that it is a step in this direction to cure some of this talk which is so carelessly used, I would say.

The CHAIRMAN. Did you finish your question?

Mr. RICH. I just want to clear that up here. So far as hospitalization is concerned, I have never heard of anybody—I do not know of anyone—who has ever criticised in any sense a service-connected veteran receiving treatment. I want to put that in the record because I have heard some criticism, but never once have I ever heard of anybody criticising a service-connected case receiving proper treatment.

The CHAIRMAN. Mr. Harvey?

Mr. HARVEY. I just wanted to make this observation: That, so far as my own district is concerned, I have had representatives down

here from the Jaycees who have presented their side of the case as well as representatives of the Legion. There is one thing that has come to my attention, and I think it is not offered particularly in the way of criticism—at least, if it is, it is constructive criticism, and I am not unmindful of the terrific task that the Legion has in attempting to inform the members of the issues at stake. But it has come to me—and I think I can say this from my own standpoint—that a great many of the members of the Legion have taken the word of the leadership over this very controversial thing without a thorough understanding of all the issues involved.

Mr. CRAIG. You say that for the other organizations that have approached you, too?

Mr. HARVEY. Yes; I say that of the other service organizations, too.

Mr. CRAIG. And nonservice organizations, too?

Mr. HARVEY. Yes. I think that a great deal of the pressure on either side at the grass roots, so to speak, has stemmed from the national level of those organizations and I am not, as I say, unmindful of the problem involved in attempting to get a thorough explanation through to them, but I think there has been a tendency, and possibly it is a natural thing, to start to pressurize Congress without many of the people there having a thorough understanding of just what they are asking for.

Mr. CRAIG. Well, it is a highly technical matter. We have given it the best study of which we are capable.

Mr. HARVEY. I am not criticising you, Commander Craig, in that respect but I think it is a fair statement.

Mr. CRAIG. It is pretty hard to get 3,000,000 people informed at the same time.

Mr. ROOSEVELT. What was the vote at the 1949 Philadelphia national convention and what was the resolution to which you referred on page 1? Was it a general resolution or was it a specific resolution?

Mr. CRAIG. Pertaining to the matter of veterans' affairs. It was a unanimous vote.

(The resolution referred to follows:)

[Res. No. 315: Reject Hoover Commission report pertaining to VA]

Whereas the objectives announced by the report of the Hoover Commission pertaining to the Veterans' Administration are opposed to long-standing policies of the American Legion; and

Whereas in particular, the Hoover Commission Report recommends that all medical services of the Federal Government be united under the jurisdiction of a United Medical Administration, and also recommends that a Government corporation be set up to administer the veterans' insurance program, both of which objectives do not meet with long-standing recommendations of the American Legion: Therefore be it

Resolved by the thirty-first national convention of the American Legion in convention, assembled at Philadelphia, Pa., August 29, 30, 31, and September 1, 1949, That the American Legion urge Congress to reject that portion of the report of the Hoover Commission which pertains to activities of the Veterans' Administration, and that we continue to oppose the centralization of all Federal hospitalization and the removal of the insurance program from the jurisdiction of the Veterans' Administration.

J. S. DEUTSCHLE, *Adjutant, Ohio.*

Approved.

Mr. ROOSEVELT. Out of the total number of employees of the Veterans' Administration what percent are members of the American Legion?

Mr. CRAIG. I cannot answer that.

Mr. HOFFMAN. We would like to have that and for the other organizations, too.

The CHAIRMAN. You can get that from the Veterans' Administration.

Mr. CRAIG. We cannot give it to you unless you require us to run the roll of 3,000,000 members.

Mr. ROOSEVELT. You know, for example, what Members of Congress are members of the American Legion?

Mr. CRAIG. I frankly do not know.

Mr. ROOSEVELT. Your Washington office knows. They send out "poop" sheets to members of the American Legion who are Members of Congress and they do not go to all Members of Congress.

Mr. CRAIG. I say you are asking me a question I cannot answer now.

Mr. ROOSEVELT. Could you look it up in the records of your national headquarters and see if you have any information on the percent of total employees of the Veterans' Administration who are members of the American Legion? I will ask the same question of every organization.

Mr. CRAIG. I will do my level best. The quickest way for me to get it would be from the Veterans' Administration.

Mr. LONGFELLOW (Henry W., executive assistant for legislation, Veterans' Administration). We would not have it.

Mr. CRAIG. Let me explain this to you. The cards of the members of the American Legion are in the files and they are kept in Indianapolis. They do not say what a man's employment is. There are 3,000,000 of them or a little better down there.

The CHAIRMAN. The Hoover Commission ought to have that.

Mr. ROOSEVELT. I am not sure they will have it.

Mr. LONGFELLOW. The Veteran's Administration will be able to furnish figures as to the number of employees who have veterans' preference but we would not be able to furnish information as to the number of employees of the Veterans' Administration who are members of the American Legion, Veterans of Foreign Wars, Disabled American Veterans, and so on.

Mr. ROOSEVELT. The reason I am asking this is that I have often been told that at least 90 percent of the employees of the Veterans' Administration are members of the American Legion and that the American Legion has a predominantly important influence over the policies of the Veterans' Administration. Now I am not sure which is right, whether that is true or not. But I am trying to get at the facts. I think it is very important that we know how much of a vested interest the American Legion has in the Veterans' Administration in determining the validity of this testimony and that of other members of the American Legion.

Mr. HOFFMAN. And also how much space they have in the Veterans' Administration here in Washington, how many desks.

Mr. CRAIG. I will take care of both those questions.

In answer to you, Mr. Roosevelt, may I say that the history of veterans' affairs in this country will bear out the fact that the American Legion has been the most vociferous critic the Veterans' Administration has had. As a matter of fact, it sent its second Administrator to the penitentiary.

Do you remember the fight between John Stelle and General Bradley? You will remember that we were constantly quarreling with them.

Mr. ROOSEVELT. I am talking about the little guy down the line, the second, third, fourth, and fifth echelon, the job holder. They have a big influence on policy as it comes up through the ranks.

I know all about the fight between John Stelle and General Bradley.

The other question I want to get at, Mr. Chairman, is perhaps more of a policy question, but I have long been of the opinion that the veterans' organizations of this country can best serve the welfare of the country and not just one group if they direct their efforts primarily toward instilling in the veterans of all wars that we are citizens first and veterans second. Now I happen to belong to an organization, and I have for a long time, a World War II organization, that has that as its slogan. I think it is all very well that a veterans' organization takes strong positions on specific legislation affecting the veterans, but I think that that should be tempered by an over-all approach.

Now the commander made a statement that the veterans' organizations would incur the hostility of the people of America if they asked for inequitable benefits, which I think was the term he used. Now the bonus is something that the American Legion pushed all through the 1930's. There is a good deal of pushing it again by the Legion.

Mr. CRAIG. That statement is incorrect.

Mr. ROOSEVELT. It is? That is delightful.

Mr. CRAIG. The latter statement is incorrect.

Mr. ROOSEVELT. Did you pass your resolution at the 1949 national convention?

Mr. CRAIG. We passed no resolution of any kind for or against.

Mr. ROOSEVELT. I am delighted to have this on the record and I congratulate the American Legion on its position.

Mr. RICH. Mr. Craig, on page 10, speaking about H. R. 5182, the last sentence reads:

> All we can see is the total abolition of the Medical Service of the Veterans' Administration.

I just cannot quite get the meaning of that term in reference to this legislation.

Dr. SHAPIRO (H. D. Shapiro, senior medical consultant of the American Legion). The Department of Medicine and Surgery is completely abolished and all out-patient departments go out.

Mr. CRAIG. Let me read to you, Mr. Rich, from section 9, subsection (a) of the bill:

> The Department of Medicine and Surgery of the Veterans' Administration is abolished, except that persons holding positions in the Medical Service, the Dental Service, the Nursing Service, or the Auxiliary Service of such Department, who are transferred to the United Medical Administration under the provisions of this act, shall be continued in their present positions until the Administrator shall have determined their qualifications for appointment in the United Health and Medical Services.

Mr. RICH. Then it has nothing to do with the abolition of the service; it is only the transfer.

Mr. CRAIG. Transferring it over to the United Medical. In other words, this is an attempt to put all Federal medicine into one administration.

Mr. RICH. It is not an abolition but a transfer.

Mr. CRAIG. It abolishes the Veterans' Administration control over medical and hospital services for veterans.

Mr. ROOSEVELT. I would like to say for the record, with respect to my last statement, that I am also a member of the American Legion, Quentin Roosevelt Post, No. 24, Oyster Bay, Long Island.

The CHAIRMAN. Mr. Hinshaw?

Mr. HINSHAW. I wish to make a brief statement myself if opportunity affords a little time.

The CHAIRMAN. Thank you very much, Commander Craig.

Mr. CRAIG. Thank you very much for your courtesy.

There is one question you asked me which I did not answer. I now have the answer for it. Th question was, How many spaces do we have in the Veterans' Administration?

Mr. HOFFMAN. That goes along with Mr. Roosevelt's statement of how many of those in the Veterans' Administration were also members of the American Legion or, I would add to it, any other veterans' organizations.

Mr. CRAIG. We have approximately 400 full-time Legion service officers who have space, temporarily or permanently, in various Veterans' Administration offices. These people who perform this service are paid by the American Legion.

Mr. HOFFMAN. I understand they just have space with other fellows to be handy to files and things of that kind.

Mr. CRAIG. Representing the veterans, whether or not they belong to the American Legion, on problems which they have coming under the law you enacted.

Mr. BONNER. You say you have 400 service officers in various offices. Now let us break that down so that this will be clear that they are not all here in Washington or in any particular office. How many officers are there?

Mr. T. O. KRAABEL (director, national rehabilitation commission, the American Legion). There are over 70 regional offices and over 100 hospitals.

Mr. BONNER. Are these service officers scattered around 170 places then?

Mr. CRAIG. Throughout the United States.

Mr. HOFFMAN. How many of them are here in Washington?

Mr. CRAIG. I cannot answer that.

Mr. KRAABEL. We have 17 members of our staff who have space in the central office or the regional office of the VA, and some in Army, Navy, Coast Guard, and Air Corps installations where we act under the law as representatives of claimants.

Mr. HOFFMAN. Here in Washington?

Mr. KRAABEL. Yes, sir.

Mr. CRAIG. I would like to direct your attention to the report of the Trundle Engineering Co. of Cleveland, Ohio, which participated in producing evidence for the task force in which they state this service was very beneficial to the over-all operation.

Mr. HOFFMAN. I should hope so.

Mr. CRAIG. And they commend it.

Mr. LANHAM. I just want to say that I appreciate the attitude you have taken toward this problem. I think, however, that your

publicity department was very unwise in sending out some of this information. I know that you had to dramatize it for your members out in the country, but it seems to me that a lot of it was very unfair. I am glad that the American Legion itself is not taking that attitude and that you are willing to sit down with us and let us see what is best.

Now there is some criticism not of the veterans program but of the fact that in some instances they have been abusing it. I think it is the abuse of these things that has caused the criticism. I frankly know of no Member of Congress who does not want to do everything that a grateful country should do for its veterans.

Let me call your attention now to this hospitalization problem and to what is happening in my own State of Georgia. It is said they are about to abandon Lawson General Hospital at the same time that they have bought the old Candler estate on Peach Tree Street and are planning to build a several million dollar hospital out there. The Army has at the same time closed Oliver General over in Augusta. They attempted to close the hospital at Dublin, Ga., which was finally reopened but has never been sufficiently staffed.

Now there is just waste in the Veterans' Administration and lost motion and if the Veterans' Administration is not going to clean it up itself, then somebody has to do it because the American people are not going to stand for this continued waste and extravagance, not only in the Veterans' Administration but in the armed services and all of the Government. That is why this Hoover Commission was established and that is why we are so intent upon finding out whether or not the Hoover Commission reports ought to be adopted.

Mr. Craig. You will be interested in knowing that the American Legion, Department of Georgia, favors the Veterans' Administration keeping Lawson Hospital at Atlanta and acquiring the Oliver General Hospital at Augusta, and not pushing for construction of the new proposed 500-bed hospital in Atlanta.

Mr. Lanham. I am glad you are.

Mr. Craig. We would favor any correction that you want to make within the structure of the Veterans' Administration in economy and efficiency.

Mr. Lanham. That looks hopeless, sometimes.

Mr. Craig. We do not believe it is necessary to tear down the whole house to fix the chimney.

Mr. Hoffman. I wish you and the other fellows who are opposing these Hoover recommendations would come up with something better. The veterans and the country need the best we can get.

The Chairman. As you go, may I say to you that, as a matter of technique, sending threatening letters to Congressmen will not get you the desired response. It rather raises an antagonism. Just as a matter of strategy, please tell my brother Legionnaires not to do it that way.

Mr. Craig. I suppose we have within the American Legion as well as in any other organization people who adopt the wrong attitude but that is not the intent, purpose, or the attitude of the American Legion.

The Chairman. We thank you, Commander Craig, for your appearance.

Mr. Craig. Thank you, Mr. Chairman.

The CHAIRMAN. Gentlemen, we have with us a very distinguished member of the medical profession in America, Dr. Charles W. Mayo, who will be the next witness following Congressman Hinshaw of California.

STATEMENT OF HON. CARL HINSHAW, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. HINSHAW. My name is Carl Hinshaw. I represent the Twentieth District of California in the House of Representatives. I am a member of the American Legion, the Veterans of Foreign Wars, and several other veterans organizations which are not so well known perhaps, but I am a member of practically all the veterans organizations to which I am entitled to membership. I am proud of that fact.

I want to speak about this bill from the standpoint of its workability and as to whether or not it would be a good thing to adopt in the Congress.

It seems to me that it would be far better if we separated the medical services of the United States Government into three parts rather than put them all into one. I have to agree with the contention of Secretary Forrestal in respect to the military services; I believe that the military services can very well be combined into one general medical organization. I think the same may be said of the Public Health Service and of the various allied branches that are elsewhere distributed throughout the Government with the possible exception of the Food and Drug Administration.

I will mention briefly the Food and Drug Administration. That is one of the agencies of Government along with the Public Health Service which is under the legislative jurisdiction of my own committee, the Committee on Interstate and Foreign Commerce. While it is true that the Food and Drug Administration does have much to do with the certification of drugs and medicine, it likewise has to do with a great many agricultural products and the canning of same and the proper condition of those products. The Food and Drug Administration is naturally closely allied with the Department of Agriculture in that respect as it deals with the processing of our agricultural produtcs, and likewise the agricultural products that may be imported in the United States for use in the United States. It would be quite a complication, I think, administrativewise to try to incorporate the Food and Drug Administration into any Public Health Service or United Medical Service. I think the committee would do well to examine into that subject as carefully as my committee has examined into it.

I have recommended a specific division into three parts. Of course everyone who comes under the military service is subject to the Articles of War and the hospital people, both personnel and patients, are likewise subject to the Articles of War. I note that in this bill you do not transfer all of the facilities of the armed services to the United Medical Service. You transfer only the general hospital services and leave the field stations necessarily assigned to ships and regiments and that sort of thing within the armed services themselves.

It would seem to me that that would create quite a complication, to try to have part of it within the armed services and part of it out-

side the armed services, as there is a matter of control of personnel involved which I think is of very high importance.

In particular respect to the Veterans' Administration and the persons who are entitled to and receive care under the Veterans' Administration, they operate under a very complicated system of rules and regulations, as you know. Part of them are set up by the Veterans' Administration itself; part of them have been enacted into law by the Congress, and other regulations have received congressional approval. They are, of course, subject to amendment in the Congress.

It is not infrequent that we receive from the Committee on Veterans' Legislation specific bills that relate directly to the regulation of the veteran in respect to veterans who are sick or disabled or who seek to establish claims for service-connected disability. My own office, which represents probably the largest congressional district in the United States in point of population, handles a great many appeals for the veteran. We always have 50 or 75 of them on file which we participate in with the veterans' own representatives. All of that involves medical testimony.

The medical officers of the Veterans' Administration are particularly keen on the subject of the regulations of the Veterans' Administration in respect to these people and it seems to me that if you take these veterans who are entitled to hospitalization and spread them out into a United Medical Service, so-called, that you would lose a great deal of the force and effect of these regulations through nonfamiliarity with them by other medical personnel who were not even basically familiar with them.

Mr. HOFFMAN. Would not those officers go over?

Mr. HINSHAW. According to this, all officers of all kinds go over, both the Public Health Service as well as the Army and Navy, but neither the Public Health Service officers nor the Army or Navy medical officers, if you please, are presumably in anywise familiar with the veterans' regulations.

Mr. HOFFMAN. I realize the force of what you say. Would not the medical officers in the Veterans' Administration go over and still handle veterans' cases when they got over?

Mr. HINSHAW. That is not provided in this bill at all. It is merely an assignment of personnel and whatever duties are performed of a medical nature, no matter who they are for, would be performed by these people.

Mr. HOFFMAN. Assuming that the Army medical officer would be in command, would he not have enough good sense to pick a fellow from the Veterans' Administration who came over and knew about it?

Mr. HINSHAW. It takes a lot more than one fellow. It takes a lot of them. As a matter of fact, I can see in a United Medical Service hospital three separate administrative groups, one group trying to handle the veterans' regulations, one trying to handle the Articles of War, and one relating, of course, to the maritime, because that comes under the Public Health Service, and then all other cases that would come before the Public Health Service.

Mr. HOFFMAN. You mean that it would repeat the experience we had on unification?

Mr. HINSHAW. Yes, I think so. I think it would be a mistake from a complicated administrative standpoint of, obviously, three separate divisions of rules, regulations, and laws and that sort of thing that

apply to the three general categories which would be handled in these hospitals.

Mr. HOLIFIELD. I would like to ask a question, Congressman. I realize that the armed services are against the relinquishing of authority over their armed service personnel, but why could not a certain number of beds in a particular hospital commensurate with the need of that particular locality be assigned to armed service personnel under a departmental head of the military?

Mr. HINSHAW. I see no reason why one service could not contract with another for the handling of a given number of veterans as they do now.

Mr. HOLIFIELD. In fact, the Veterans' Administration is placing some of their patients in Army and Navy hospitals under contract and in private hospitals under contract.

Mr. HINSHAW. Yes, that is correct, but the regulation aspect of it is still handled and channeled through the Veterans' Administration center which sent them there.

Mr. HOLIFIELD. As far as the veteran is concerned?

Mr. HINSHAW. As far as the veteran is concerned.

Mr. HOLIFIELD. But assuming that the major hospital operation is the Veterans' Administration, they are the contractor themselves, there would be no reason why the Army and the Navy could not send in their personnel to that hospital under contract with the Veterans' Administration?

Mr. HINSHAW. I can see no reason why that should not take place although of course they are outside of the jurisdiction of the Army if they are sent to an outside hospital temporarily.

Here under subsection (d) on page 7 you provide—

> Any member of the Army, Navy (including the Marine Corps), or the Air Force, or of any reserve component of either when in an active-duty status, may be assigned or detailed for duty or training in the United Medical Administration.

That includes enlisted personnel. If you assign enlisted personnel of the armed forces to a general Government hospital, what happens to all of the reports that the sergeant major has to make concerning his personnel? You have to have a completely separate unit in there or you have lost military control over these people.

There is one more thing involved in it. The rules of service of these different people are different. There is no limit, for example, to the time that the Army, Navy, or Air Force can work its personnel. There is no 8-hour day, nor any 5-hour day, or 12-hour day. They can work them as long as they like. They do not as a matter of fact, of course, except in time of emergency, war, and that sort of thing. That is not true of the civil service. The civil-service person has a totally different and specific set of rules by which he is governed in his service to the Government.

Now I assume that the rules of the Veterans' Administration and the Public Health Service are very similar in that respect because they are civil-service employees, but the medical personnel, the technical personnel of the United States Public Health Service, are set up in grades and ranks very similar to the armed forces. They have ranks such as lieutenants, captains, and other grades. I cannot just now remember what they are but they are set up in that way and as a unit they may be taken into the armed forces in time of war.

But that is not true in the Veterans' Administration. The Veterans' Administration is a civil-service organization so that you have all of those complications that are involved between these different people.

It says here in subsection (d):

> The assignment or detail, or the transfer, of any such member to the United Medical Administration shall be without loss of or prejudice to his status in the Army, Navy, or Air Force, or reserve component thereof.

In other words, it is going to be a heterogeneous outfit at best with all kinds of grades and ranks and prerogatives and privileges all messed up and mixed up together. I do not see how it can possibly work that way.

I think if you make a division into three parts, you will have accomplished something and make arrangements for contractual assignments as between those three segments, depending upon the availability of space.

Mr. ROOSEVELT. I am inclined to go along with you wholeheartedly on your picture of the confusion of personnel status and also the confusion within the hospital handling the various cases that would come to it. What I am worried about is that under the present set-up there is no minimum of flexibility. Where you have a vacancy in an Army hospital right next door to a Veterans' Administration hospital, an overcrowded Veterans' Administration hospital, there is really no flexibility to permit the overflow going into the Army hospital. There is some.

Mr. HINSHAW. I would have to disagree with you.

Mr. ROOSEVELT. In some there is.

Mr. HINSHAW. Until recently there was an Army general hospital located in my home town of Pasadena. They maintained I think 100 or 150 beds to the order of the Veterans' Administration. The same thing was true of the Long Beach Hospital under a contractual arrangement.

Mr. ROOSEVELT. We have situations in several places where the Veterans' Administration will be abandoning one hospital and building another one and yet there are two or three armed services hospitals that are almost vacant. It seems to me we could arrange an over-all board over all these medical services which would have limited authority governing the construction of hospital units, governing, say, the purchasing, even of all the utilities that are bought by all of them, which would accomplish some savings and prevent the overlapping especially in these construction problems.

Mr. HINSHAW. I might agree with you on that. That might have a great deal of merit. There is obviously a surplus in some places and a shortage in others. It is quite possible that an over-all service or an over-all board——

Mr. ROOSEVELT. With limited power——

Mr. HINSHAW. Should arrange such things.

Right now, for example, we have two very large military facilities being closed in the State of California, one, the Long Beach Hospital, and the other one at Corona, which is a former resort place. Each has a capacity of 1,500 to 1,700 beds. At the same time we have what we in California think at least is a shortage of beds for the Veterans' Administration, a material shortage in view of the great numbers that have flocked out there since the war.

Mr. ROOSEVELT. Such a board, it seems to me, would overcome the apparent jealousies and rivalries of each independent group wanting to keep as much geographical area and as much of the facilities under its own control.

Mr. HINSHAW. I want to point out one more difficulty that is involved in this, and Mr. Holifield is familiar with it.

In the State mental institutions in the United States and in the State, county, and city jails of the United States we have literally thousands of veterans of this last war. They got there by virtue of having gone berserk some way or other committing some crime which perhaps was not a crime in the sense that they were not totally responsible for committing it. Something was wrong with them mentally. Now there is a type of mental disease, generally speaking, a mental difficulty which is different from nearly any other. Of course I must admit, and we all must admit, that some of these cases are just ordinary mentally deficient persons. That is not normal, of course, but they are subject to all the difficulties that everybody else is subject to, but at the same time the large part of them have had battle training of a sort which led them into violent conflict. At times they go off their nut and when they do that they revert to this battle training that they had and go out and shoot the place up or run around with knives and that sort of thing and maybe think they are back on the battlefield some place in France or on one of the islands in the Pacific temporarily. At least that conflict enters into it.

That type of fellow needs a very special treatment. He needs our sympathy and consideration. He should not be put in a jail. He should not be put in a State mental institution along with all the perverts and everybody else you find in a State mental institution. He should have a specific type of care which would take away from him this terrible thing which comes over him when he sees people being killed in his dreams. Yet, if you put all of these people together in a mental institution, you have the same situation that exists now in a State institution where you have everybody, particularly perverts, all grouped together with everybody else who may be criminally insane or otherwise.

I do not think that is a good thing. I do not think it is the right treatment for the veterans of our country who have had to serve in these horrible battle situations. They should have special and loving care and attention by our Government.

Mr. ROOSEVELT. Is there any method now by which they can be transferred from a State institution for the criminally insane or otherwise to a Veterans' Administration hospital?

Mr. HINSHAW. There would be if there were enough veterans' hospitals for the neuropsychiatric insane available but we have at least 3,000 in California who are in State institutions.

Mr. HOLIFIELD. That is right; and we have had for several years now two new psychiatric hospitals authorized by Congress, one for the San Francisco area and one for the Los Angeles area, and yet as far as I know, no specific steps have been taken in the Los Angeles area. I understand some preliminary steps have been taken in San Francisco to build these particular types of hospitals which Congressman Hinshaw speaks of.

In the meantime, approximately 3,000 of these people are in our State institutions.

Mr. HINSHAW. They are sleeping on mattresses in the hallways and without adequate facilities for even their personal care.

Mr. HOLIFIELD. We have these large Army and Navy hospitals with perfect facilities or facilities which can be adapted, which are being deactivated and the Veterans' Administration is refusing to take them over.

Mr. HINSHAW. I must condemn the Veterans' Administration for their refusal to take over such of these installations as are at all suitable for this purpose. The Corona installation is certainly suitable for the purpose, although it is not what the Veterans' Administration would build for themselves if they stepped out and built one.

The CHAIRMAN. Congressman, what would you have to say about the fact that we have a shortage of doctors? The Veterans' Administration must be furnished with them also. In taking over these hospitals that are being abandoned because they do not have the personnel, the Veterans' Administration would then have to have the personnel to do it. They are short now.

Mr. HINSHAW. This business of transferring this medical personnel into a united medical set-up is not going to retain those people in the service.

The CHAIRMAN. I agree with you.

Mr. HINSHAW. A lot of them who may like to wear a uniform and have the brass on them, and so forth and so on, are going to say, "To hell with this, I will go back to civil life where I can make some money." I do not think it is going to work out at all. A man goes into the Navy because he loves the Navy. If he is a naval medical officer, he likes to be a naval medical officer. The same thing is true of the other services, they have a personal liking for it. I do not think this bill is going to retain in the service anything near the quantity of medical personnel you want.

The CHAIRMAN. It is your opinion that the Federal medical service can best be administered by having our Military Establishment take care of its needs?

Mr. HINSHAW. Yes, sir.

The CHAIRMAN. And by having our Veterans' Administration deal with the fellow who was in the Army and to whom special consideration has been shown by the Congress, and then have the general public, the children, disabled and others, under a medical set-up to take care of them?

Mr. HINSHAW. That is what I firmly believe, Mr. Chairman.

The CHAIRMAN. Thank you very much, Congressman. You have given us a very fine analysis of the situation and we are, indeed, grateful to you.

Mr. BONNER. In other words, I think he has annihilated the bill. That is what I think the witness has done.

The CHAIRMAN. He has done much in that direction.

Mr. LANHAM. There is another recommendation along the same line made by the Hoover Commission to the effect that there ought to be some organization for the building of hospitals. It just occurred to me that the Bureau of Public Buildings within the General Services Administration probably ought to do that and prevent this duplication of construction. That seems to be the trouble. Why should the Veterans' Administration construct hospitals when they have not the staff to operate them?

Mr. HINSHAW. Mr. Roosevelt brought that up a little while ago. I am inclined to agree. It might be that the General Services Administration with the proper board set-up could, let us say, guide the design of hospitals because they are very specialized units.

Mr. LANHAM. They probably should also control the disposition of the services.

Mr. HINSHAW. Exactly so. I think that would be a very good idea. We could utilize all of these things that are now available.

Now Mr. Holifield and I are both members of the Joint Committee on Atomic Energy. He and I have listened to a lot of testimony which we cannot repeat here naturally, but when you get into the subject of atomic energy and potentialities of a future war, there are proper locations for a hospital that are not in the center of big cities. Now we have listened to this testimony. I do not like to repeat it here. Perhaps the press would consider this entirely off the record because we do not want to publish it at this time, but certainly there are areas outside of these places, these big cities, where these hospitals should be, where they might receive any people who would be victims of radiation exposure or otherwise. It is imperative they not be in the center.

The principle of the Veterans' Administration is, within recent years, to establish hospitals that are close to medical educational centers and they are almost invariably in the center of some big city. That is exactly the wrong place to establish them.

Mr. HOLIFIELD. I agree 100 percent with the Congressman on this point. I want to point out, and this is a matter of public record that in the atomic bombing of Hiroshima 90 percent of the nurses, doctors, and hospital facilities were completely eliminated. Now all we have to do is take that public information which has already been released and apply it to Chicago, New York, Los Angeles, or any other city and it shows how vulnerable the present situation is in massing these hospitals in large population, industrial, residential, and port centers, and how necessary it is that some of these outlying hospitals which are not convenient in peacetime, such as the Corona hospital some 30 miles from Los Angeles, not be deactivated but be maintained in our total Government hospital set-up.

Mr. HINSHAW. The gentleman is absolutely correct and that refutes the present plan completely. It makes it all the more necessary that we keep those things open and operating.

The CHAIRMAN. It seems to me further that the great question is doing something about the shortage of nurses and doctors.

Mr. HINSHAW. We have that subject before my committee right now. I am supposed to be down there acting on it.

The CHAIRMAN. It cannot be handled by the veterans. It cannot be handled by the military. But it can be handled by, and it is part of the responsibility of, the Public Health Service.

Mr. HINSHAW. I think that is right.

The CHAIRMAN. Thank you very much, Congressman. It has been a pleasure to have you with us.

Mr. HINSHAW. Thank you.

The CHAIRMAN. At this time I am going to ask Dr. Rowntree to present to us our distinguished guest, Dr. Mayo.

Dr. ROWNTREE. Ladies and gentlemen, I have the pleasure of presenting Dr. Charles W. Mayo of the Mayo Clinic. He is also, may I

say, the chairman of the Medical Advisory Board of the Veterans' Administration and he is vice chairman of our advisory board in the American Legion.

The CHAIRMAN. I would like to express further to Dr. Mayo, and what I believe to be the opinion of this committee and every American, our thanks for the wonderful medical services he has rendered to the people of this Nation through his institution. We are indeed happy to have him with us.

STATEMENT OF CHARLES W. MAYO, M. D., MEMBER, MAYO CLINIC, ROCHESTER, MINN.

Dr. MAYO. Thank you very much, Mr. Chairman.

I should really be there in one I think instead of being simply a doctor. I should be a lawyer and an orator, too.

There is only one attribute I have so far as my presentation is concerned and that is it is brief. Before starting with any discussion of that, however, if I may be permitted, I would like to say in regard to what has been presented by Mr. Hinshaw and by your summary that the American Legion has asked that the Federal Board of Hospitalization be reactivated to take over the function which was discussed, that is in connnection with hospitalization, with the various organizations taking over of Federal medicine. What has happened to that, I do not know, but I would imagine that it might be a good organization to take charge of hospitals, how they should function, in regard to the care of the various Federal medicines.

Mr. HOLIFIELD. Mr. Chairman, in agreeing with Dr. Mayo's statement I would like to ask that the Chairman of the Federal Hospitalization Board be brought before us some time during the hearings.

Dr. MAYO. The Legion asked that it be reactivated.

Dr. SHAPIRO. It was done away with 2 years ago. We have a mandate from our Philadelphia national convention asking for reactivation of the Federal Board of Hospitalization just for the purpose of what is being discussed today.

(The resolution referred to follows:)

[Res. No. 585: Reactivate Federal Board of Hospitalization]

Resolved by the Department of Pennsylvania Convention assembled, The proper resolution asking the Federal Board of Hospitalization be reactivated in order that it may function as a responsible body as it has in the past to properly make recommendations for the construction of additional veterans hospital beds.

EDWARD A. LINSKY,
Department Adjutant, Department of Pennsylvania.

Approved with amendments.

Mr. HOLIFIELD. Can you give us testimony at some appropriate time on that subject, giving us the function of the previous Federal Hospitalization Board?

Mr. KRAABEL. May I say that Mr. Cliff, one of the witnesses scheduled for today, goes into that very thoroughly.

Mr. HOLIFIELD. Thank you.

Dr. MAYO. I will go ahead with this brief statement.

In discussing H. R. 5812 before this committee, I am not presenting the opinion of the Mayo Clinic, or of the Special Medical Advisory Group of the Veterans' Administration, or even that of a mem-

ber of the Medical Advisory Board of the American Legion, but rather my own individual opinion. Dr. Rowntree, as chairman of the Medical Advisory Board of the American Legion, expresses the majority opinion of that group.

Prior to putting forward any opinion, I would like to express my admiration and respect for Mr. Herbert Hoover and the working committees under him, and for the objectives of their studies. I also would like to state that what I have to say naturally has been influenced by my service in the Medical Corps of the Army in World War II and by my association with the Veterans' Administration and the American Legion since my return to civilian status in November 1945.

I do not believe that H. R. 5182 will be able to attain its objectives, chief among which are to preserve health of all those in the armed services, to perform the functions now delegated to Public Health Service, and to take over the Veterans' Administration and perform its obligations, as designated by Congress, with very substantial economic saving and with increased efficiency. To accomplish this end, section 2 of this bill would establish a new Government agency known as the United Medical Administration, the Administrator to be appointed by the President with the advice and consent of the Senate. The Administrator shall perform his functions subject to the direction and control of the President. He is to have three Assistant Administrators appointed by the President, also with the advice and consent of the Senate, who shall perform such functions as the Administrator shall direct. The bill also directs that the Administrator shall establish a special advisory board and other committees of medical and allied professions to advise him or such other officers of the United Medical Administration as he may designate.

During and after World War II, I, like many other civilian medical men who served (principally those who belonged to the Army and Air Corps) was firmly of the opinion that by unification of medical effort in the armed services much waste and reduplication could be avoided, and economy and greater efficiency accomplished. I still believe this to be true in peace or war. This should be possible of accomplishment with a minimal temporary loss of dignity and esprit de corps to any of the armed services and with preservation of those medical specialties peculiar to each service.

From this limited thought, others have developed the plan epitomized by H. R. 5182. To the uninitiated, the bill, first read through, would appear on the surface to be a panacea. To me, H. R. 5182 attempts to gather under one roof too much for it to hold administratively, economically, or efficiently.

The Public Health Service is an old and well-established governmental organization; it has performed excellently its functions of protecting the health of our people in those categories for which it was formed. It did not get into trouble until its leaders delved into political issues.

The bill in question would take into the United Medical Administration, lock, stock and barrel, the Public Health Service, change its name, give it no representatives on the advisory board and make no provision for the protection of the career officers of the United States Public

Health Service such as is provided for officers of the Army, Navy, or Air Force.

I am of the opinion that the United States Public Health Service can remain as such, confine itself to its intended purposes, grow, keep within our national economy, and operate with increasing efficiency.

The Veterans' Administration, as you are aware, operates the largest insurance agency and the largest hospital and group medical organization in this country. It can rightfully boast that it gives the veterans of this country who are entitled to its services by act of Congress, finer medical care than is available in any other country of the world. This enviable record and rapid attainment of it since the conclusion of World War II has been due to splendid administration, untiring efforts to get rid of those restrictions which entailed red tape and adherence to the motto "medical service second to none." This meant drawing to the service of the Veterans' Administration top flight medical men, dentists, nurses, and auxiliary medical services, many at personal financial loss. We who have been associated with the Veterans' Administration feel that one of the most important steps which contributed to the present quality of medical care was the removal of doctors, dentists, and nurses from the civil service. As I read H. R. 5182, this bill would return them to civil service, and to this I am opposed.

Should the Veterans' Administration be included in a United Medical Administration as now proposed in H. R. 5182, with its Administrator acting only in the capacity of an adviser on the advisory board to the Administrator of a United Medical Administration, with no representation by a, shall I say, Surgeon General of Veterans, I doubt that it would be possible to keep the quality or quantity of medical, dental, or nursing personnel necessary to maintain for the veteran a "medical service second to none." Such a move in my opinion would be an act of medical regression, not progression, would be false economy, and would result in loss of efficiency.

I have tried to make my remarks brief and to the point. They stand as my present opinion regarding H. R. 5182.

The Chairman. Dr. Mayo, you are of the opinion that much of the efficiency of the veterans medical service hangs upon the sentiment and hearts of the men who have served and who are now out in the practice and who at a personal loss are willing to give of their time and knowledge and services to aid the veteran?

Dr. Mayo. I think that is true. I think the same summary could be made of what I believe you stated following Mr. Hinshaw's statement.

The Chairman. Thank you.

Mr. Holifield. Doctor, in your testimony you bring to my mind certain things which I know exist in our service, particularly to the Armed Service members at the present time. We have in certain areas a conflict in terms of service, at least of Naval hospitals and Army hospitals. We even have cases where the hospital of one service or the other is not used very much and we have another branch of the service building a hospital. I can see certain difficulties in bringing the military service hospitals in under Veterans' Administration, for instance, but is there any real reason why all the members of the Armed Services could not be treated in a single hospital within a single area?

Dr. MAYO. As far as my personal opinion is concerned, I see no reason why they cannot.

Mr. HOLIFIELD. Would that not eliminate duplication of facilities, duplication of staffs, and utilize more completely the present limited facilities and personnel which we have?

Dr. MAYO. In my opinion it would.

Mr. HOLIFIELD. So at least there is a field that could be explored for economy and efficiency?

Dr. MAYO. In other words, I believe within our present set-up as it exists today it is going to improve and will improve with the efforts put into it and that cooperation is probably the biggest thing we need among all services.

Mr. HOLIFIELD. The elimination of duplication.

Dr. MAYO. In other words, I do not believe that the Veterans' Administration should take over the functions of Public Health. If they want research in public health, then probably the thing to do is to transfer somebody from Public Health to the Veterans' Administration for that purpose. In other words, it would be cooperation among all services.

Mr. HOLIFIELD. Is it possible also that economy and efficiency could be achieved through the purchase of all governmental hospital supplies through a single purchasing agency as now provided for in Public Law 152, the General Services Administration Act, where the Federal Bureau of Supplies is authorized to purchase for civilian, and military under certain conditions, supplies which are needed by different Government agencies?

Dr. MAYO. Yes.

Mr. HOLIFIELD. You do admit that you have duplications of stocks of medical equipment, duplication of stocks of medical supplies and medicines in the condition that now exists?

Dr. MAYO. Right.

Mr. HOLIFIELD. I am sure that you would approve of any move that would help to solve that problem of waste in Government if we could work it out so that it would not be of detriment to the Veterans' Administration's people?

Dr. MAYO. That is correct.

Mr. HOLIFIELD. Do you also feel that this Federal Hospitalization Board should be reactivated?

Dr. MAYO. I agree with that. I believe in what the Legion has asked for in connection with reactivation of the Federal Board of Hospitalization. I think it would be an important board in an advisory capacity.

Mr. HOLIFIELD. Would you give to that Board anything other than advisory power? Would you give to it, for instance, the problem of determination as to whether hospitals should be built in certain areas, or whether certain hospitals that are now being deactivated should be taken over rather than building new construction?

Dr. MAYO. Dr. Shapiro tells me that they had that power before. Of course I would want to know who was on the Board before I gave them too much authority.

Mr. HOLIFIELD. Unfortunately we cannot legislate here for personalities. We have to legislate on general principles and general provisions.

I believe that these hearings may bring out some method that may not be according to H. R. 5182, but I do believe you will agree with me that there is a field for making our Government function a little more efficiently and economically?

Dr. MAYO. That is right; I am all for it.

Mr. HOLIFIELD. Thank you.

The CHAIRMAN. Mr. Harvey?

Mr. HARVEY. No questions.

The CHAIRMAN. Mr. Bonner?

Mr. BONNER. Doctor, there is one thing that has interested me, the preparation of armed services medical officers. What would be your opinion with respect to a national medical academy to prepare the Medical Corps of the armed services?

Dr. MAYO. This is a personal opinion. I would think that it would be unnecessary. I do not think there is enough difference in the care of people outside of very special things that would make it essential to have a medical school only for the Federal medical group.

Mr. BONNER. Since we go to the expense of training officer personnel for national defense, should there be attached to it scholarships placed in medical schools, give them to medical schools for that specific purpose?

Dr. MAYO. That might very well work, if it is done on the basis that they give an equivalent amount of time to national defense.

Mr. BONNER. They agree to give time to national defense.

Dr. MAYO. There would be a certain amount of gambling to it because all of them would not get through.

Mr. HOLIFIELD. Dr. Mayo, I think this is an important point that our colleague has brought up. Do you think that the Congress should address itself to this shortage of doctors and nurses, the general overall shortage of doctors and nurses in the Nation to the extent of considering legislation which would increase possibly by scholarship aid or loans to medical students, or the providing of facilities, the number of dentists, doctors, and nurses?

Dr. MAYO. I do not know quite how it could be legislated. I think that is something that natural progress in population and demand is going to take care of without legislation. I do think that studies of that nature are good and I think that it stimulates progress. It makes people aware of the fact that something is necessary but I do not think that it should be by legislation.

Mr. HOLIFIELD. You are not satisfied, are you, with the present supply of doctors and skilled medical technicians in the country?

Dr. MAYO. There is an alleged shortage. It may be that it is partly on the basis of the places where they are short not having sufficient attraction.

Mr. HOLIFIELD. We know that there is. There is no doubt that there is a shortage. I tried to get a dental appointment and was told that I could not get it until the end of May.

Dr. MAYO. Try another dentist.

Mr. HOLIFIELD. My office called up several dentists and being a stranger in Washington, only having lived here 8 years, the story was that it was the best I could get. Some of them said it would be 3 months or 4 months before I could get an appointment. That condition exists. If you go into any doctor's office in my home town, you will find 25 or 30 people sitting in the anteroom waiting to be treated

by one doctor. That applies to any doctor in town, regardless. They are all good doctors as far as I am concerned.

Mr. BONNER. You would have to wait a month to get an appointment with Dr. Mayo. Now you have a chance.

Mr. HOLIFIELD. I do not think we need to belabor the point of shortage. Certainly it is something that should be given some attention.

Dr. MAYO. The commander was interested in getting into the problem of increasing by 10 percent enrollment in the various medical schools because it might help take care of the attrition.

Mr. HOLIFIELD. Do you have interest at all in Federal aid to the education of doctors? I am not talking socialized medicine; I am talking about filling a national need as we fill a need for bridges and other Federal grants-in-aid, such a program, of course, completely under State jurisdiction and private control.

Dr. MAYO. I think it is a matter of great interest. I would say that should Federal aid be given in these cases under State control, it perhaps should not be started until they have finished their sopohomore year in medical school, at least into their junior year, if the necessity should be shown. I would like to know that if Federal aid is given, it was going to be returned to the people in some manner.

Mr. HOLIFIELD. On a loan basis possibly?

Dr. MAYO. I do not think, for instance, it should be started out with a freshman or sophomore.

Mr. HOLIFIELD. Because of the number who drop out?

Dr. MAYO. The number that drop out and the number that turn out no good.

Mr. HOLIFIELD. Can you give us information as to the degree of facilities to train these people?

Dr. MAYO. Of course, that is another difficulty because all doctors are not teachers and we do not want to get back in this country to the quality of medical school which we had prior to 1910. We have to be extremely careful that the schools maintain the quality of their teaching staff.

Mr. HOLIFIELD. At the present time there is quite a waiting list in most of the recognized medical schools?

Dr. MAYO. There is because there has been created in the minds of a great many people that there is a great demand for an increased number of doctors in various fields.

Mr. HOLIFIELD. You do not question the need, do you? In your statement you state there has been created in the minds of the people that there is a great demand for an increased number of doctors.

Dr. MAYO. There may be an excessive demand, let us put it. If you want to become a doctor, I think it is either born in you and you want to do it or else you go into it because of a demand.

The CHAIRMAN. Thank you very much, Doctor. We are indeed grateful for your contribution.

Dr. MAYO. Thank you.

The CHAIRMAN. We have one more witness, Mr. Earl V. Cliff, of the American Legion.

Mr. KENNEDY. This witness is Mr. Earl V. Cliff who is a member of our special committee, and has been for a number of years very active on behalf of the Legion in connection with rehabilitation work and he is also very familir with the workings of the Veterans' Administration.

On his behalf I respectfully request permission of your committee to allow him to present his testimony at this time.

The CHAIRMAN. I would like to make a statement to those assembled here.

As you remember, these hearings were scheduled to begin last week. We had to postpone them at that time because a disapproving petition was filed to one of the President's plans. Under the law we are required to report to the Congress on it, hold hearings and report to the Congress within 10 days from the time it is filed.

I have also been advised that yesterday a disapproving petition was filed to plan No. 6 by Members of Congress and it will necessitate our holding hearings on that particular plan beginning tomorrow morning.

Mr. BONNER. What is that?

The CHAIRMAN. That is on labor, the one affecting the Department of Labor, filed I think by Congressman Lucas. So when we adjourn today, we will adjourn subject to call and give those of you who have not been heard and all interested people notice as to when the hearing will be continued.

Mr. KENNEDY. In that case Mr. Cliff and I would ask that you hear Dr. Rowntree who has come up here from Florida.

STATEMENT OF LEONARD G. ROWNTREE, M. D., CHIEF MEDICAL ADVISER, THE AMERICAN LEGION

Dr. ROWNTREE. Mr. Chairman and members of the committee, I have heard nothing anywhere more heartening than this discussion here today. I want to congratulate you on this hearing because I think you are bringing out piecemeal the difficulties in this bill. We are all interested in something that will be worthwhile and I think this committee itself is exposing the weaknesses in this bill as it stands.

With your permission I should like to speak of this in a very personal way because I have a very personal relationship. You can go from the particular to the general and I am going to answer a great many questions that have been asked from personal experience in dealing with them myself.

If I might be permitted to answer one question of yours, sir, in the war it was my suggestion that we set up a plan that gave us 13,500 doctors in excess of those that we would have had, had we not adopted a plan of all-out effort on the part of medicine during the war.

Now this personal experience of mine I think is unique. I think I have seen all sides of this problem in a small way in person because. I have been for 6 years the chief medical adviser of the American Legion. Hence, I have been in touch with all that it is doing and with all the contacts with the veterans' hospitals. I have also been for 4 years the chief consultant to the veterans hospital at Coral Gables, Fla., and have been chairman of the deans committee that carries on education and research in that institution. I think perhaps I can also speak with authority and in a general way on the care of the sick, since I have been in practice 45 years. I started out as a general practitioner. I worked with the laboratories in research at Johns Hopkins. I was associate professor at Hopkins, later a professor of medicine, and then the senior consultant and chief in the Mayo Clinic

for many years. Following that, I worked in the field of research as the director of the Philadelphia Institute for many years.

I have also seen much of military medicine. I served in the First World War as executive officer for the Medical Air Service abroad and in the last war I served throughout under Presidential appointment as Chief of the Medical Division of Selective Service.

It is because of that work I am in this work. I was asked because I helped to bring these men in. I should continue my interest and see what could be done to help them.

Now for 4 years I have been in and out of the veterans hospital at Coral Gables. It is second to none in quality of service in that part of the world. I believe it is the best medical service in the world.

Second, it is limited strictly to those who are eligible by law and are adjudged individually in need of hospitalization.

Third, it is less costly than other medicine in our part of the country, $13.50 a day compared with $15.50 for the municipal hospitals which we also have in Miami.

Now this is carried on in a satisfactory converted hotel, the old Biltmore. It served the Army. We took it over from the Army. The Army acquired it at a ridiculously low price. It would take $10,000,000 to duplicate the same. But it is a satisfactory hospital for the purposes for which we now use it.

However, it is running too full. We have from 101 to 107 percent of the authorized occupancy and it is in immediate need of expansion.

The only criticism that I have of this hospital is that we have an organization to determine who shall and who shall not be admitted, who is eligible. Every day 90 to 100 people knock on our door and ask for hospital service. Those are all veterans and only those who are eligible and in need of hospitalization are accepted.

Mr. HOLIFIELD. How many of that 90 to 100 are accepted?

Dr. ROWNTREE. Let us say on an average of 8 to 12.

Now this screening is too close. When you try to screen out from 100 people who come, all feeling that they need hospitalization, you have to proceed with extreme care to make certain that you do not leave out the man who is going to die if he is not hospitalized. So that I feel this is wrong. We should not be subjected to that degree of screening but we must do it.

Now there are two things that have been suggested here today that I would like to touch on. They have been suggested to us. The first one is that we will have extra beds activated. We have 100 beds. You say you have 6,000 empty beds. We have 100 of them, we have 100 empty beds in our hospital. You are told that these beds cannot be activated because they cannot be staffed. Why can they not be staffed? The staff will come in if we have the funds. It is lack of funds to pay the personnel, we are told that in black and white, and we have said unless we can have the number of personnel necessary to give adequate care, it is better to leave those beds vacant. We cannot afford to give second-rate care to sick veterans. So we leave them unoccupied until such time as we can get funds for the personnel.

I am saying these things and you can multiply them a hundred times when it comes to other hospitals.

What else has been suggested? We are running from 101 to 107 percent of the authorized occupancy. We have been told quietly that

we should not do that, that we should never take more than we are authorized. In fact, it should be cut down to the normal hospital level of 85 percent occupancy to leave room for emergencies, and so forth.

We have almost a perfect hospital.

Now these are types of economy that I wish you would scan in anything you do. Do not let us have second-rate medicine. Do not let us have shoddy medicine. Let us have first-class medicine such as we are getting today.

The CHAIRMAN. You say if you had the funds you could get the personnel to staff them?

Dr. ROWNTREE. More.

The CHAIRMAN. You say this could be repeated many times throughout the country?

Dr. ROWNTREE. I am going to say this holds for us but in answering the questions for us, we recognize similar situations in other sections of the country.

The CHAIRMAN. If we are short of doctors and nurses and if additional funds would permit you to get additional nurses to staff yours and this would be applied to the other hospitals, I cannot see that anybody would be left to wait upon the civilian population.

Dr. ROWNTREE. I feel as the Congressman does; I think there is a need for more doctors myself. I set up the program during the war that produced those doctors.

The CHAIRMAN. Do you not believe that such a program can be followed in time of peace by a nonmilitary set-up?

Dr. ROWNTREE. I question that, Mr. Chairman. That was a war effort. It was of the spirit, it was of men working overtime to meet the war need; but I concur that we do need more doctors. We within the Veterans' Administration have a larger group of psychiatrists than anyone else in America. We have 600 psychiatrists under training and we have in every teaching hospital a group of young doctors who are coming in to be trained so that they will not be simply a garden variety but will be able to give superior service.

The CHAIRMAN. Doctor, what plan could you offer to supply America with the needed doctors and nurses to serve the people of America, those in the service, veterans, and the public generally?

Dr. ROWNTREE. I think what we have to do is to appeal to the hearts of the people. Only certain people should be doctors. The chief characteristic, according to Hypocrates, is the desire to be a doctor.

The CHAIRMAN. Now we have these long waiting lists of men who have already expressed their desire, who are trained up to that point to qualify. How can we get those men into training in order to supply the needs of the country?

Dr. ROWNTREE. I would say, Mr. Chairman, as I am going to say later, that we cannot do this by hasty steps. We have issues created by two wars and by a changing civilization. That is our problem, that is your problem; that is not a problem that can be shoved over to a little committee to solve, the problems that we have been discussing today. I have heard more intelligent suggestions today around this table than I have found in this bill.

The CHAIRMAN. There are those of us who think, Doctor, in the light of what happened just before the last war when we were calling up men for the service and found so many were rejected.

Dr. ROWNTREE. I was in charge of that.

The CHAIRMAN. Proper medical care would have prevented their rejection.

Dr. ROWNTREE. I do not know the answer but I think I am quoted as saying that 8 percent of those who were rejected had remediable defects. The vast majority of those people did not have things that could be quickly remedied.

The CHAIRMAN. Had they had certain medical care over a long period of time there would not have been such a large number of rejections.

Dr. ROWNTREE. I agree with you. I also agree with you if we had proper mental training we would not have had these mental cases.

The CHAIRMAN. To my mind it is just as essential to protect the human beings of this country from a health standpoint as it is to protect the land and the farmer. We ought to look after the general American citizen. What plan have you evolved to furnish this country with sufficient doctors to protect the general health of the people of America?

Dr. ROWNTREE. The plan that I did evolve I was in a position to evolve. I suggested it to the committee of deans of the American Medical Association and they adopted it. As I stated, in 6 years it produced 13,500 doctors in excess of what we would have had, but I do not believe that that is applicable in peacetime. I think that every doctor who stayed home to train those men overworked and many of them paid for it later in broken health. But I do think we should face the fact that we should have more doctors.

I am with the veterans' hospital simply as a consultant and we are trying to train men in medicine.

Mr. HOLIFIELD. In other words, you are saying that you are doing possibly more training in your veterans' hospitals than in private hospitals or municipal hospitals. Is a large percentage internships?

Dr. ROWNTREE. We have no internships. These are residences and they come in for 3 years' training.

The CHAIRMAN. But they are already doctors.

Dr. ROWNTREE. Yes, they are doctors who are trying to become doctors on a higher plane, the same thing that the Mayo Clinic does.

The CHAIRMAN. How are we going to get the mass of doctors? We need doctors to start off with. You take them after they are doctors and train them but we do not have enough doctors to serve the general public efficiently.

Dr. ROWNTREE. If you can appoint a committee in some way to look into that, I think it ought to be decided. I cannot give you the answer here now. I did give you the answer during the war.

Mr. HOLIFIELD. That was your V training?

Dr. ROWNTREE. Yes, it took them in, but we had every medical school running 12 months a year. Every medical school was filled to capacity and as much above capacity as they could humanly handle. Every school responded. At the close of the war those men could not stand that pressure, neither could the students. We broke a lot of students because 36 months of continuous work such as they were doing was too much for them.

Mr. HOLIFIELD. We do not want to be caught in that position again and that is why it is an important subject.

Dr. ROWNTREE. You have a tremendous problem and I agree you need help, but I am not in a position to make a plan as I was in the war.

Now I would like to answer the question whether in this hospital that I am interested in there are any of the types of economies that have been suggested that could be practiced. I will come back to that in a moment. So far as I can see, there is no waste in that hospital. I sit in on everything. Further significant economy in my mind cannot be effected except at the price of service either in quality or quantity.

Mr. HOLIFIELD. I think again you are not taking a very fair position there when you apply it to your particular hospital because the United Medical Report was for the over-all Government obligation of hospitalization. I think you are narrowing down the application.

Dr. ROWNTREE. I asked to express a personal opinion based on personal experience because I do not know this broad situation.

Mr. HOLIFIELD. This bill is directed to the complete subject of general hospitalization.

Dr. ROWNTREE. Yes, and I will give my opinion of that bill as we proceed. Until we can take care of our veterans who are in the numbers of 90 to 100 a day seeking admission, I do not think those beds should be used for anyone else. We do not have enough beds for our own veterans.

Mr. HOLIFIELD. Are there additional Army or Navy hospitals in that area which are not crowded?

Dr. ROWNTREE. I am glad you brought that up. I do not know how many of these beds that have been called vacant are like we have but we have an Air Service hospital there that has been abandoned. It is not any good to us, it is not any good to anyone.

Mr. HOLIFIELD. When was it abandoned and why?

Dr. ROWNTREE. At the end of the war. It is of the temporary type that cannot be used. This Biltmore is a magnificent building but it is a hotel. It cost us probably one-tenth of what it would cost to build.

Nor can I see—and I am trying to be strictly honest—how this bill could help us one iota in solving our local problems of taking care of the veterans. What is true of this hospital is probably true of many more.

I have explained to you several of the things that you cannot see on the surface. We can cut down on the patients or throw them out or we can take an inferior number of personnel and give second-grade care. That is not good medicine and I do not think we should do it.

Now who are the people who receive care in this hospital? Only sick veterans, colored or white, who are adjudged eligible according to law and adjudged worthy of hospitalization by the physicians in charge. There we have the halt, the lame, and the blind. We have the veteran whose body is shattered by wounds and undermined by disease. We have the veteran whose joints are swollen and twisted by rheumatism and arthritis. We have the veteran whose intestines are tattered from dysentery. We have the veteran whose lungs are riddled with tuberculosis. We have the veteran whose heart valves have sprung leaks. We have the veteran whose nerves are jittery and on edge and we have the veteran whose mind is unhinged and diseased.

Why do we have all of these? Because the Veterans' Administration believes in balanced hospitals.

Then if you take the statistics of the stay in hospitals, you cannot treat a mental disease patient and get him out in 3 days. You cannot take tuberculosis and cure it in 2 months. These people stay until they are cured, if they can be cured, and that accounts for the length of stay in many of our veterans hospitals.

These are the people that I see daily. This is the type of people where we could practice pennywise economy. Are these the types of people that we should shove out of the beds for others? If you were able to visit these hospitals and see its workings, I think you would find that most of them are full, running efficiently, and that they have a spirit on the part of the staff which makes institutions great. You cannot have great institutions without great spirit working.

Now we come to this bill H. R. 5182. As you surmised, I am utterly and unalterably opposed to it as it stands. It abolishes the medical service of the Veterans' Administration. I see no mention of the improvement in the care of veterans and I see no mention of a continuation of the residency program of teaching and research.

In dealing with this bill I will speak only on the medical aspects because I can discuss only particulars about which I know.

Now, first, this states that "the Department of Medicine and Surgery of the Veterans' Administration is abolished except" the professional personnel holding positions in the Department of Medicine and Surgery Medical Service, Dental Service, Nursing Service, or the Auxiliary Service who may be transferred to the United Medical Administration shall be continued in their present positions until the Administrator shall have determined their qualifications for appointment in the United Health and Medical Service.

Now let us apply that to our hospital. The manager is a man who is a colonel in the Army. He is as good a doctor as you will find anywhere. He is an absolutely first class administrator and he is 55 years old. He should not go on probation.

The chief of professional service has been in this for 19 years. I was offered a very high position recently. Had I taken that position, I would have tried to bring that man with me as my deputy. He should not go back to have somebody determine whether he is qualified to do what he has been doing efficiently for 19 years.

As a result of the actions of Congress, the Veterans' Administration in good faith entered into contractual relationship with the medical profession whereby they enlisted the aid of leaders in the profession. The Medical Service of the Veterans' Administration, which was second class—and called third class, as you remember, in the literature—within the past 5 years has been converted into a first-class service, medically second to none. It is far above the average municipal service and it bids fair to compete with university hospital service. For the first time the veteran is now receiving the type of medical service that he needed and wanted and which he paid for in advance by his service, and which was financed and provided for and granted by Congress. Congress provided it.

And now we, the people, and you, the lawmakers in Congress, are being told by a reorganization committee that the program is "waste-

ful and inefficient" and that for reasons of economy the Department of Medicine and Surgery of the Veterans' Administration should be abolished. This bill constitutes a breach of faith. It breaks faith with the veteran, with the people of these United States still free, with the Veterans' Administration, and with the medical profession. Such a breach of faith undermines the integrity of the Nation and the confidence of the people in its government.

Mr. HOLIFIELD. I realize you feel strongly on this point, but I think your statement is beyond the facts of the case.

Dr. ROWNTREE. May I read you the next paragraph and quotation?

Mr. HOLIFIELD. I would like to make this point. While your Department of Medicine and Surgery would be abolished from an organizational standpoint, no function or no service to the veteran would be abolished. I am not saying that in defense of the bill but I am saying that in defense of fair play.

Dr. ROWNTREE. Do you know that they are going to have residency training? Neither do I; it is not mentioned.

Quoting Newsweek magazine for March 20, 1950, this is what the Chief Medical Director of the Veterans' Administration said to the medical fraternity back in December 1945:

> You will be given free rein, unhampered by Washington, if you will just pitch in and help.

As a result,

> Hundreds of famous specialists dropped lucrative practices to join this crusade.

Now this is 5 years after that promise and now we are told that this bill abolishes the Department of Medicine and Surgery of the Veterans' Administration.

In my opinion the recommendations of the Hoover Commission so far as they concern medicine are based on insufficient knowledge of existing needs, and this was brought out by your hearing this morning better than I could ever tell you. We do not even have the figures. I have heard much better suggestions here than are in that bill. I think Mr. Hinshaw's suggestions were much wiser.

I believe the opinions of the Hoover Commission are unjust in principle and I believe they will prove unsound in the solutions they offer to the problems that we face.

Now this bill is based on these recommendations. It sets up a new executive agency, the United Medical Administration, with an Administrator and three Assistant Administrators. It provides authority for this new organization to take over and run, with minor exceptions, all Federal medicine in this country with such advice as the Administrator can obtain from special committees and an advisory board meeting 2 hours a month. This board is composed of the surgeons general or Administrators of the four great services. These are all career men. They know the needs of their special services. They are qualified to direct these services but they will be relegated to an advisory capacity. This bill will make all the present medical leaders in these services subservient to political appointees, be they what they may. This act will break faith with the veterans who preserved our liberty, in one quick, callous step, and will wipe out the identity of several Federal agencies of which our Nation is justly proud. There is no service in this Nation that has done finer work than the Public Health.

I served in the Army, in its magnificient medical service, but in time of war they have 75,000 civilian doctors to help them. I served in the Air Service in the pioneer days but the Air Service, so far as I know, is not represented; nor is the Public Health, so far as I can determine, represented even in an advisory capacity.

I personally feel a tremendous pride; these organizations are great because they have great spirit. I believe to do what we have done here will undermine morale.

Now if we need a change in our Federal medicine, let such change be based on adequate, prolonged, and unbiased investigation. You gentlemen here have asked most intelligent questions, meaning that we have not all the information. Let such change be based on truth and truth only. I am avoiding a great deal of discussion that has come up on other things because, God help me, I do not know what is true and what is not true, there have been so many things said. Let the change be just within the existing organizations and above all let it provide superior medical care to all in need who are entitled to such care.

Now I am giving you an honest opinion. I think we have to face the issue. I do not think that we as the people or the Government should evade our responsibility in these great issues. They have grown out of World War I and World War II and in a changing civilization. Let us not evade these issues by pushing them off on a new Government agency with an Administrator and three Assistant Administrators. Let us not ask the organization to solve these great medical issues that now face us. These problems are ours. They are the problems of us, the people, and of you, our representatives. These problems need more careful study, more extensive investigation, and they call for wise action. Let us not be evasive or precipitous. Let us explore all the possible solutions for our problems before we act irrevocably. This bill evidences zeal but in my opinion zeal without wisdom.

At present our Federal service is good in the several departments, it is excellent. Let us not alienate the medical profession of this country by going back on what we promised 5 years ago. Not let us sacrifice what we have attained through years of progress for an ill-advised, all-out experiment which assures us nothing in the way of improvement in the care of the sick, and the cost of which is still to be determined.

Now I have come up from Florida, gentlemen, because I felt it was a duty. I have seen these things, I have lived through them. I believe we would do a much wiser thing to table this, carry on investigation, learn the truth, learn the needs, find just and effective solutions to our problems. That I do not believe can be effected through an Administrator and through the Assistant Administrators.

The CHAIRMAN. Doctor, I appreciate deeply what you have said and the way in which you have said it and the contribution you have made to our country in meeting its problems. I am a Legionnaire. I am a member of the Veterans of Foreign Wars and I am a member of the Disabled American Veterans of World War I. To my mind this question is one of the greatest that now face us, the health of the people of America, and I cannot understand the opposition of what seems to be the great mass of doctors to the wonderful things you have said exist in your Public Health Service, in your veterans set-up, and in

your Army service, and you have gained it from experience. I cannot understand how they can support, as they seem to do, the bulk of the medical fraternity of this Nation, administration of this kind in the light of men who have had their own profession, who have had experience in all branches of the service, and who know the present medical needs of the people of this country. The organized opposition that the medical fraternities of this country are giving to this bill has been one of the greatest surprises to me.

Dr. ROWNTREE. These things I cannot understand, sir, either. Throughout the war I was chairman of the Joint Committee on Physical Fitness, fought for it day in and day out. I am vice chairman of the National Committee on Mental Hygiene. The needs of the people are infinite. We are not meeting them adequately, but I think we would do better to study our problems and find good solutions than take an irrevocable step and commit multiple errors which time and expense may not serve to lessen. My advice is, let us know what we are doing; let us know our problems before we act.

Mr. HOLIFIELD. What does it cost today, Doctor, to educate a doctor from the time he leaves his preparatory college work and takes specialized training? What does it cost in terms of dollars?

Dr. ROWNTREE. I cannot tell you but I can tell you certain things about it. In the first place, most schools now want a degree, an A. B. degree. That means 3 or 4 years of education. In Canada they have a combination system. It takes 4 years to go through the medical school. It takes 1 or preferably 2 years for internship. That is to become an ordinary practicing doctor. Beyond that are these specialist boards, and they take from 3 to 4 years of additional training. So there are 13 to 14 years involved in making a top-notch doctor provided you start with something that was worth working with.

Mr. HOLIFIELD. Now I have put a few children through college myself. I am not speaking of the medical colleges but of the regular colleges, and it costs at least $1,500 a year. That is being modest, I think, for the ordinary college. Now what is your cost in these medical colleges? What is the tuition?

Dr. SHAPIRO. From $500 to $600.

Mr. HOLIFIELD. Of course, an individual has to sustain himself during that period of time.

Dr. ROWNTREE. We have done away pretty well with people in overnight schools. They are all closed.

Mr. HOLIFIELD. So you have close to $20,000 invested in your career at the end of 13 years.

Dr. ROWNTREE. I would say that is a modest amount.

Mr. HOLIFIELD. At least that much. In view of that fact, do you not feel that there are many young men and young women who have all that they need to be doctors except the money that is needed to go through that long training period?

Dr. ROWNTREE. I do.

Mr. HOLIFIELD. We learned that through our V program during the war, which I am glad to find out was under your direction.

Dr. ROWNTREE. It was not under my direction. I set up the plan and offered it to the deans.

Mr. HOLIFIELD. We will give you credit for being the father of the plan then. The Federal Government invested quite a bit of money

in these boys. We did put on forced draft and get, as you say, 13,500 doctors we would not have had otherwise.

Now we are in peacetime and, of course, we cannot put on that degree of force draft. That does not mean that we cannot do something toward supplying this deficiency throughout the Nation.

Dr. ROWNTREE. I will give you the figures. The figures I have received indicate that there are approximately 24,000 people, individual people, applying for entrance into medical schools; 6,000 are accepted.

Mr. HOLIFIELD. That is an annual application?

Dr. ROWNTREE. That is annual.

Mr. HOLIFIELD. In other words, 18,000 of these young men and young women are being refused the opportunity for medical training each year.

Dr. ROWNTREE. Many of them are probably not worth while. As Dr. Mayo pointed out, the first 2 years you find out pretty well who is and who is not going to be a doctor.

Mr. HOLIFIELD. That is right, there is always a screening period that has to be gone through. We are not saying that all 13,500 doctors we manufactured during the war are good.

Dr. ROWNTREE. Neither do we say that of those 6,000 doctors who come through each year.

The CHAIRMAN. We thank you, Dr. Rowntree, for the statement you have given the committee. We appreciate your coming up here.

(The statement referred to of Leonard G. Rowntree, M. D., chief medical adviser, the American Legion, follows:)

STATEMENT BY LEONARD G. ROWNTREE, M. D., CHIEF MEDICAL ADVISER, THE AMERICAN LEGION

PERSONAL EXPERIENCE IN THE CARE OF THE SICK, INCLUDING VETERANS

From personal experience I can discuss the medical care of the veteran, since for 6 years I have served as chief medical adviser of the American Legion, and for 4 years as chief consultant to the veterans' hospital in Coral Gables, Fla., and as chairman of the deans' committee in charge of medical teaching and the residency training program in that institution. I can also speak with authority on the care of the sick in general, since it has fallen to my lot during the last 45 years to practice as a general practitioner, as a research worker in the laboratory, as a professor of medicine, as chief of medicine and senior consultant to one of the greatest medical clinics (Mayo), and as director of the Philadelphia Institute for Medical Research. During the Frst World War I served as a commissioned medical officer with the Air Force, and during World War II I served throughout under a Presidential appointment as Chief of Selective Service, Medicine Division. From this experience I am entitled to a personal opinion, and I can state positively that the medical service in the Veterans' Administration hospital in Coral Gables, about which I am thoroughly informed (1) is second to none in quality for our community; (2) is limited to those who are eligible and in need of hospitalization; (3) is less costly than similar services in our municipal and good private hospitals; (4) is carried on satisfactorily in a converted hotel (Biltmore), acquired at a ridiculously low cost (by transfer from the Army), to reduplicate same, it is estimated, will cost $10,000,000; (5) is running from 101–107 percent of its authorized capacity (450 beds); (6) and is in need of immediate expansion.

The only criticism I can offer is that there is too close screening of applicants. We are compelled to refuse admission to many people who are in dire need of hospital care. Ninety to one hundred applicants daily knock at our doors. It is true that there remain 100 empty beds, not as yet authorized for patient occupancy, not because of inability to staff such beds but because of lack of funds to furnish the necessary personnel. If such funds are forthcoming the hospital will immediately function to capacity at a cost per bed well below that of our local municipal hospital.

We have been advised that the beds will be activated if we are willing to accept personnel far below the service need of the additional patient load. This we have declined, feeling that beds are better empty than filled with patients who will be inadequately treated.

Likewise it has been suggested that the beds be employed at 85 percent of capacity. Since every patient in the hospital is there because he needs hospitalization, this likewise we have refused. (Off the record: Our manager retorted, "I do not need this job that badly. I would rather resign than be a party to injustice to the sick.")

These are the types of economy we should avoid now and in the future.

In the Veterans' Administration hospital at Coral Gables there is no apparent waste. Further significant economy is possible only at the cost of reduced quality of service. Until our own veterans are cared for the service should not be shared by others. Nor can I see wherein a United Medical Administration would improve our medical service or lower its cost.

What is true of the hospital at Coral Gables will be found true in many if not most of the other Veterans' Administration hospitals, and especially in all teaching or deans' committee hospitals.

WHO RECEIVES MEDICAL CARE IN THE VETERANS' ADMINISTRATION IN CORAL GABLES?

(1) Only the sick veterans, colored and white, who are adjudged eligible.

(2) The veteran who is halt, lame, or blind.

(3) The veteran whose body is shattered by wounds or undermined by disease; the veteran whose intestines are tattered from previous dysentery; the veteran whose lungs are riddled with tuberculosis; the veteran whose heart has sprung leaky valves; the veteran whose nerves are jittery and on edge; the veteran whose mind has become unhinged or diseased.

These are the people I see daily in the Veterans' Administration, and these are the people who can be found in any Veterans' Administration hospital. Is this the place for a great nation to start to exercise penny-wise economy? Are these the people to be displaced if their beds are to be shared by others? If you were able to visit all the Veterans' Administration hospitals I believe this is the picture that you would see. Once you had seen this picture and these patients I believe you would leave the Veterans' Administration as it is, and feel that it meets the needs and at a cost that is reasonable.

H. R. 5182

As you may have surmised, I am utterly and unalterably opposed to the proposed bill H. R. 5182, since it abolishes the medical service of the Veterans' Administration, makes no special mention of the care for the veteran, or of the continuation of the residency training program. In dealing with this bill I will speak only on the medical aspects, and with that viewpoint I make the following observations on its most objectionable features.

Section 9 (a) states, "the Department of Medicine and Surgery of the Veterans' Administration is abolished except" the professional personnel holding positions in the Department of Medicine and Surgery medical service, dental service, nursing service, or the auxiliary service who may be transferred to the United Medical Administration shall be continued in their present positions until the Administrator shall have determined their qualifications for appointment in the United Health and Medical Service.

The Veterans' Administration was set up by Congress after World War I to administer the affairs of veterans. It was consolidated under one head on the insistence of President Hoover for reasons "of efficiency and economy." After World War II the needs of the veteran were again carefully appraised by a number of agencies, including the Federal Board of Hospitalization, and finances were authorized and allocated by a grateful Congress representing a grateful nation whose liberty the veterans valiantly preserved. A new and better regime was inaugurated, including better care for the sick, active participation in medical research, a teaching (residency) program for the training of young doctors.

As the result of the actions of Congress the Veterans' Administration in good faith entered into contractual relationships with the medical profession whereby they enlisted the aid of leaders in the profession. The medical service of the Veterans' Administration, which was second or third class, within the past 5 years has been converted into a first-class service, medically, second to none. For the first time the veteran is now receiving the type of medical service that

he needed and wanted and which he paid for in advance by his service, and which was financed and provided for and granted by Congress.

And now we the people and you the lawmakers in Congress are being told by a reorganization committee that the program is "wasteful and inefficient" and that for reasons of economy the Department of Medicine and Surgery of the Veterans' Administration should be abolished. This bill constitutes a breach of faith. It breaks faith with the veteran, with the people of these United States still free, with the Veterans' Administration, and with the medical profession. Such a breach of faith undermines the integrity of the Nation and the confidence of the people in its Government.

As Mr. Cliff has pointed out, the talents and professional experience of the outstanding men of medicine, medical institutions of learning and clinics, were sought by the Veterans' Administration for service to and care of veterans. This was the premise upon which they were asked and upon which they accepted.

Quoting Newsweek magazine for March 20, 1950, this is what the Chief Medical Director of the Veterans' Administration said to the medical fraternity back in December 1945: "You will be given free rein, unhampered by Washington, if you will just pitch in and help." As a result, "hundreds of famous specialists dropped lucrative practices to join this crusade."

In my opinion the recommendations of the Hoover Commission so far as they concern medicine are based on insufficient knowledge of existing needs, are inadequate in scope, unjust in principle, and unsound in the solutions they offer to our problem. H. R. 5182, based on these recommendations, sets up a new executive Government agency, the United Medical Administration, with an administrator and three assistant administrators. It provides authority for this new organization to take over and run (with minor exceptions) all Federal medicine in this country, with such advice as the administrator can obtain from special committees and an advisory board meeting 2 hours a month, composed of the surgeons general or administrators of the four great services. All career men know the needs of their special services, are qualified to direct these services, but will be relegated to an advisory capacity. This bill makes all our present medical leaders in these services subservient to political appointees, be they what they may. This act will break faith with the veterans who preserved our liberty, in one quick, careless step, and will wipe out the identity of several Federal agencies of which our Nation is justly pround. It will weaken and destroy the morale that made these organizations great. It will commit multiple and irrevocable errors that even time and experience may not be able to remedy.

If we need change in our Federal medicine, let such change be based on adequate, prolonged and unbiased investigation, on truth and the truth only (not twisted statements), and let it be just within the existing organizations, and above all let it provide superior medical care to all in need who are entitled to such care.

Gentlemen, I am giving you my honest opinion. We must face the issue. Let us not evade our responsibility in the great issues growing out of two world wars and out of a changing civilization. Let us not evade these issues by pushing them off on a new Government agency with an administrator and three assistant administrators. Let us not ask the new organization to solve these great medical issues that now face us. These problems are ours. They are the problems of us the people and of you our representatives. These problems need more careful study, more extensive investigation, and they call for wise action. Let us not be evasive or precipitous. Let us explore all the possible solutions for our problems. This bill evidences zeal, but in my opinion zeal without wisdom, unfortunately. At present our Federal service is good. Let us not alienate the medical profession of this country nor sacrifice what we have attained through years of progress for an ill-advised, all-out experiment which assures us nothing in the way of improvement in the care of the sick, and the cost of which is still to be determined.

Dr. ROWNTREE. Would it be possible for Mr. Cliff to be heard? He has come a long way.

The CHAIRMAN. Mr. Cliff, could you put your statement in the record and at some further hearing if you wish to return we shall be glad to hear you.

66188—50——5

(The statement referred to follows:)

STATEMENT BY E. V. CLIFF, MEMBER OF THE EXECUTIVE COMMITTEE, NATIONAL REHABILITATION COMMISSION, THE AMERICAN LEGION

HISTORY OF VETERANS' HOSPITALIZATION

It would seem desirable in view of the statement just made by George N. Craig, national commander of the American Legion, to review briefly the history of the program for Federal hospitalization of war-disabled veterans. It is submitted that the experience of the American Legion, over a period of three decades, justifies us in coming before you to state our objections to the passage of H. R. 5182.

FEDERAL BOARD OF HOSPITALIZATION

At this time, our organization desires to be recorded as recommending the re-creation of a Federal Board of Hospitalization.

We believe that such a Board can provide an effective means of assisting Congress to arrive at proper decisions in matters of hospital construction, hospital maintenance, hospital locations, the needs of the several Federal agencies operating hospitals, and the complete utilization of total services and facilities of the Federal Government, in time of war and in time of peace.

In recommending the establishment of a Federal Board of Hospitalization, the American Legion is cognizant of the need to maintain hospital facilities suitable for the three distinct and separate types of medical programs now established, viz:

1. Curative and rehabilitative veterans' hospitals: (*a*) General medical and surgical, (*b*) tuberculosis, and (*c*) mental.
2. Preventive medicine.
3. Military medicine.

Membership of such a Federal Board of Hospitalization should include represenatives of all Federal agencies operating hospitals. In addition, there should be a representative of the public at large, i. e., the non-Federal hospitals.

Such a Board should have, so far as is possible, complete authority in determining where and when hospitals shall be constructed or expanded. Additionally, the Board should have authority to transfer (within the limits of available appropriations) from one Federal department or independent agency to another, such hospitals (or partial capacities of such hospitals) whenever necessity (or economy and efficiency) so require.

This recommendation for the creation of such a Board is correctly a part of the history of the Federal hospital and hospitalization, since there was such a Board in operation from November 1, 1921, to June 30, 1948.

The following information regarding the previous operation of the Federal Board of Hospitalization is extracted from Committee Print, Eightieth Congress, second session, titled "An outline of the manner in which sites are selected and funds authorized for the building of hospitals and homes for the care of former members of the Armed Forces." This document was printed for the use of the Committee on Labor and Public Welfare.

"The Federal Board of Hospitalization was created, by direction of the President, on November 1, 1921, for the purpose of coordinating the hospital activities of the Medical Department of the Army, the Bureau of Medicine and Surgery of the Navy, the United States Public Health Service, the United States Veterans' Bureau, St. Elizabeths Hospital, and the Office of the Commissioner of Indian Affairs. For approximately 3 years, the Board functioned under the supervision of a Chief Coordinator, who was appointed by and directly responsible to the President. In 1924, a reorganization of the Board placed its activities under the chairmanship of the Director of the United States Veterans' Bureau and provided that its recommendations should be transmitted to the Director of the Bureau of the Budget for the consideration of the President.

"Until the early 1940's, projects for the provision of hospital facilities for war veterans comprised the great majority of cases referred to the Board for consideration as there was little activity in the field of hospital construction by Federal agencies other than the Veterans' Administration prior to World War II. With the expansion of the military branches just before and during the early months of the war, a corresponding increase in Army and Navy hospital facilities occurred.

"To prevent overbuilding and duplication and to insure that postwar needs would be given adequate consideration in the planning of hospitals to care for current requirements, the President, on March 31, 1943, revised the organization of the Board, and directed that no further hospital or convalescent facilities should be acquired within the continental United States by the War and Navy Departments, the Federal Security, or the Veterans' Administration, until such projects had been submitted to the Federal Board of Hospitalization for review and recommendation to him as to location, type or construction, and other factors affecting the over-all requirements for postwar hospitalization. An exception was permitted in the case of emergency installations made necessary by epidemics or similar situations, and a later amendment to the directive also authorized the Army and Navy to acquire temporary facilities of fewer than 150 beds without approval of the Board.

"In addition to the duties incident to this review of all Federal hospital projects, the President directed that the Board undertake a study of the complete problem of the hospitalization of the veterans of World War II, and the development of an over-all plan for meeting this responsibility of the Federal Government."

The purposes of the former Federal Board of Hospitalization were stated to be:

"The Board shall initiate studies of and analyze and review the hospital, convalescent, and domiciliary activities and programs developed and operated by all departments and establishments for the purpose of—

"(*a*) Preventing the overlapping and duplication of services and overbuilding of facilities.

"(*b*) Insuring the most efficient and complete utilization of the total services and facilities of the Federal Government by each department and establishment.

"(*c*) Determining the need for existing or additional facilities of each department and establishment.

"(*d*) Determining the area or locality in which additional facilities should be provided.

"(*e*) Determining the extent to which non-Federal facilities may be utizied in the administration of the hospital activities or programs of any department or establishment.

"(*f*) Developing a complete over-all program for providing hospitalization for the veterans of World War II.

"(*g*) Furnishing recommendations with respect to such matters as the Director of the Bureau of the Budget may refer to the Board.

"No project for acquisition of additional beds by new construction, major alteration, or leasing of or contracting for existing facilities shall be undertaken by any department or establishment until it has been submitted to and reviewed by the Board as to need, location, type of construction, and any other factor which the Board may consider pertinent to the performance of its responsibilities, nor until the resulting recommendation of the Board has been transmitted and considered as provided hereof, and approved by the President.

"The above, notwithstanding, (1) any department or establishment may acquire additional beds to meet a temporary seasonal, epidemic, or emergency requirement, provided such acquisition does not require new construction, and (2) the War and Navy Departments may acquire limited hospital facilities involving temporary type of construction only, and not exceeding 150 beds for any one project, provided no other Federal hospital facilities are available within a reasonable distance. Each project involving the acquisition of beds, under this subsection, shall be reported to the Federal Board of Hospitalization at the time approval thereof is given by the head of the department or establishment concerned."

THE PROBLEM IN 1918

On Armistice Day, November 11, 1918, there were 334,112 sick and wounded soldiers in hospital beds in this country and overseas. At the same time, there were available for the care of discharged disabled veterans only a few thousand beds in the hospitals and homes built for veterans of prior wars, including 7,200 beds in the Public Health Service.

RESPONSIBILITY WAS DIVIDED

At the same time, there were eight different agencies administering to the needs and welfare of veterans, as follows: (1) Bureau of Wark Risk Insurance,

(2) Public Health Service of the United States, (3) Federal Board for Vocational Education, (4) National Home for Disabled Volunteer Soldiers, (5) Medical Department of the Army, (6) Medical Department of the Navy, (7) Department of the Interior, (8) private and public (contract) hospitals.

Some time after the Armistice was signed, the Public Health Service was able to furnish 12,000 beds, but, because of the fact that this agency was primarily trained and adapted to the practice of preventive medicine, as distinguished from curative medicine, it was soon found that this arrangement was insufficient to solve the problem of the sick and disabled veteran.

The statement that 12,000 hospital beds were furnished for the use of the Public Health Service does not mean there were that number of beds in buildings constructed as hospitals. Many of these beds secured were placed in old and dilapidated buildings. In other cases, buildings designed as schools were adapted. Mount Alto in Washington was a girls' school.

FACILITIES WOEFULLY INADEQUATE

In the effort to improve the conditions existing, contracts were made with private hospitals to provide hospital service for the war disabled. This was not always a happy choice. There were cases of medical racketeering. Mushroom hospitals sprang up. There was evidence that, in many cases, there was more interest in getting the dollar provided for the veterans' benefit than in giving the service contemplated by the Congress for the veterans care. Not until the Federal Government embarked upon the program of constructing new, specially designed hospitals for the physical and medical rehabilitation of the veteran was there permanent improvement in the operation of the program.

THE DAWES COMMISSION

The general situation of the administration of veterans' rights by eight different bureaus brought about so much confusion, together with lack of facilities, that many of our disabled veterans were confined in penal institutions throughout the country. This brought forth protests from all over the Nation. The situation became so acute that President Harding appointed a special commission, headed by Brig. Gen. (later Vice President) Charles G. Dawes, and 10 other distinguished Americans, to study the problem.

A quotation from the findings of the Dawes Commission group is illustrative of the conditions existing at that time:

"Three distinct and separate governmental agencies without a common authority were created for and are now engaged in executing the laws for the relief of the disabled, namely, the Bureau of War Risk Insurance, the Rehabilitation Division of the Federal Board for Vocational Education and the United States Public Health Service. The result is that the ex-service person finds it extremely difficult to obtain the prompt, generous, and sympathetic treatment which the Congress and the country intended he should receive."

As a result of the recommendations of this Commission, all of the agencies administering veterans' benefits (except the Pension Bureau and the National Homes for Volunteer Soldiers) were combined in one agency known as the Veterans' Bureau. This agency was established on August 9, 1921. This consolidation was not only in the interest of economy and efficiency, but also for the most important purpose of fixing responsibility in the administration of the welfare to sick and disabled veterans. We know now that one of the main objectives of the Dawes Commission was to fix the responsibility for proper care of veterans.

POLICY ON ELIGIBILITY ESTABLISHED

The Veterans' Bureau established its own hospital system, and began the construction of veterans' hospitals. In 1924, the Congress, by enactment, set the policy for these hospitals, as follows:

"The Director is further authorized, so far as he shall find that existing Government facilities permit, to furnish hospitalization and necessary traveling expense to veterans of any war, military occupation, or military expedition since 1897, not dishonorably discharged, without regard to the nature or origin of their disability: *Provided*, That preference to admission to any Government hospital for hospitalization, under the provisions of this subsection, shall be given to those veterans who are financially unable to pay for hospitalization and their necessary traveling expenses."

The latest general statement with regard to Congress' definition of veterans is contained in Public, 312, Seventy-fourth Congress, approved August 23, 1935. Therein, Congress stated:

"In addition to the pensions provided in this title, the Administrator of Veterans' Affairs is hereby authorized, under such limitations as he may prescribe and within the limits of existing Veterans' Administration facilities, to furnish to men discharged from the Army, Navy, Marine Corps, or Coast Guard for disabilities incurred in line of duty, or to those in receipt of pension for service-connected disability and to veterans of any war, including the Boxer Rebellion and the Philippine Insurrection, domiciliary care, where they are suffering from permanent disabilities, tuberculosis, or neuropsychiatric ailments and medical and hospital treatment for diseases or injuries: *Provided*, That any veteran of any war, who was not dishonorably discharged, suffering from disability, disease or defect, who is in need of hospitalization or domiciliary care, and is unable to defray the necessary expenses therefor (including transportation to and from the Veterans' Administration facility) shall be furnished necessary hospitalization or domiciliary care (including transportation) in any Veterans' Administration facility within the limitations existing in such facilities, irrespective of whether the disability, disease, or other defect was due to service."

PRESIDENT HOOVER'S RECOMMENDATION

In 1929, Herbert Hoover, then President of the United States, made the following recommendation to Congress (2d sess., 71st Cong.):

"I am convinced that we will gain in efficiency, economy, and more uniform administration and better definition of national policies if the Pension Bureau, the National Home for Volunteer Soldiers, and the Veterans' Bureau are brought together under a single agency."

Congress accepted the President's viewpoint, as contained in this recommendation, and on July 3, 1930, the Veterans' Bureau was replaced by the Veterans' Administration. This present agency incorporated the Veterans' Bureau, the Pension Bureau, and the National Home for Volunteer Soldiers in the one unified agency—the Veterans' Administration.

THE VETERAN POPULATION

It must be remembered that the total personnel in World War I was approximately 4,800,000. Today, there are approximately 19,000,000 veterans. If we can draw any conclusion from past experience, certainly it would be that the dismemberment of the present Veterans' Administration into five agencies would cause great confusion to a greater number of beneficiaries. Certainly, it would not result in either economy or efficiency, and the dividied responsibility would only create an opportunity to pass the buck, which does not exist under one unified agency.

There was confusion in the operation of eight separate agencies handling the veterans' benefit program for 4,000,000 veterans. Consider the situation that would be created were the benefits programs of some 19,000,000 veterans divided among five new and separated agencies.

AS TO THE SO-CALLED NON-SERVICE-CONNECTED CASES

While no definite statement was made in the report of the Hoover Commission with respect to the care of alleged non-service-connected veterans, there is an implication in the request that the Congress redefine who are to be the beneficiaries of Federal hospitalization, together with the publicity put out by the supporters of the Hoover Commission report that the so-called non-service-connected veteran is to be greatly affected. The public is led to believe that these beneficiaries of Federal hospitalization are costing the American taxpayer large sums of money. I wish, therefore, to discuss with you briefly the problem of the so-called non-service-connected case.

First, I want to point out that there are 2,014,578 (February 1950) veterans who have established service connection for their disabilities, according to the records of the Veterans' Administration. Such veterans are entitled to medical care and hospitalization, when necessary, without dispute. This classification is being increased in numbers constantly. All these men were listed as non-service-connected veterans until they established their service connection with the Veterans' Administration.

As of November 30, 1949, the records of the Veterans' Administration show that there were in beds in this country a total of 106,427 sick and disabled veterans. Of this total, 35,910, or 34 percent, were listed as service connected. Sixty-nine thousand two hundred and forty-one, or a total of 66 percent, were listed as non-service-connected veterans.

Of this 69,241 so listed, 8,652 were suffering from tuberculosis and 30,307 were suffering from mental disorders. No one disputes the fact that these non-service-connected T. B. and N. P. (insane) veterans should be taken care of in veterans' hospitals. Neither the American Medical Association nor the American Hospital Association are interested in taking care of these veterans. They are public charges, and must be cared for by the taxpayer, either in his county or State, or by the Nation.

In view of the fact that these men served in the Armed Forces during the time of war, the uncertainty surrounding the origin of their disability, even in the minds of medical men, is so great that Congress has provided for their care in veterans' hospitals. When you add this 38,959 to the service-connected group of 35,910 it makes a total of 74,869. Subtracting that figure from the total hospitalized of 106,427 leaves a balance of 31,558.

It is estimated that approximately two-thirds of this balance are suffering from chronic diseases, such as advanced cardiac vascular disease, chronic arthritis, and chronic neurologic disabilities, all hospitalized over a period of 60 days. They, too, are public charges to be taken care of either locally by the county or the State, and in many localities, there are no adequate facilities to take care of them.

That leaves us a balance of approximately 10,000 non-service-connected veterans still to be accounted for. Of the 10,000 we have asked the Veterans' Administration to prepare a complete breakdown. Though check has not been completed, the American Legion is confident that many of the 10,000 are veterans hospitalized pending adjudication of their claims for service connection, and that still more are service-connected veterans now in hospitals for treatment of disabilities other than those connected with the service, but directly affected thereby, and that the balance are overwhelmingly in the indigent class, and would be public charges in any event.

The statistics show that there is only 7½ percent of the patient-days spent in general medical cases among the so-called non-service-connected remaining 30 days or less in veterans' hospitals. The care of these sick and indigent veterans, who have no other place to turn for medical aid, is surely an investment in democracy. The Legion does not believe there is any intent on the part of Congress to deny them the privilege that has been theirs, through congressional approval, since the early years after the Civil War.

I point this out to you at this time for the reason that any claims of savings or economy by changing the present policy, as fixed by Congress in 1924, would be negligible. On the other hand, if all the non-service-connected T. B.'s and N. P.'s were to be turned out of the Federal hospitals of the Veterans' Administration, the additional cost of constructing hospitals and furnishing hospitalization by the respective States and communities would amount to huge sums. Would that be in the interest of efficiency or economy?

MEDICAL SCIENCE HAS NOT DETERMINED THE CAUSATIVE FACTORS

Sometimes, it is believed it is too easy to shrug off the claims of the veteran who has not been able to provide from records, that never were in his care or keeping, the proof that his disabilities were service connected. It is the veteran who, in this sense, may be termed the forgotten man that the Legion meets daily in his rehabilitation work.

These men were presumed to be sufficiently healthy to be accepted for military duty. They carry honorable discharges, as proof of such service. Though medical science has not found an exact method of determining the causative factors for many of the veteran's disabilities, the burden has been on the veteran to provide that exact proof. In many cases, he has been unable to accomplish this purpose. On the other side, however, the Legion knows of many cases where service connection was secured after long months and years of effort.

VA MEDICINE DURING WORLD WAR II

The American Legion has been probably the greatest critic of the Veterans' Administration and, particularly, of its medical service. From the day that separate service was set up until the conclusion of World War II the Legion criticized

not only the system but, in many instances, the personnel. It is our contention that there were some good doctors and that some good medicine was practiced in the Veterans' Administration prior to setting up this new medical program. There were, however, many defects such as the following:

1. The Medical Director was under a lay assistant administrator in charge of medical and hospital services.
2. There was no adequate training program for specialists in the various fields of medicine.
3. There was no time given to specialists trained in medicine to attend medical meetings to better prepare them in the practice of this profession.

The whole situation could best be described as bureaucratic medicine. Because of the failure of the Veterans' Administration to heed the continued warnings of the American Legion, our organization, at its convention in 1941, in Milwaukee, passed the following resolution:

"Medical Service of Veterans' Administration, national convention of the American Legion held in Milwaukee, Wis., September 15 to 18, 1941:

"Whereas for a number of years, the national rehabilitation committee of the American Legion has pointed out to the Administrator of Veterans' Affairs and his staff certain apparent deficiencies in the medical service of the Veterans' Administration; and

"Whereas repeated promises have been made by the Veterans' Administration to correct these admitted deficiencies; and

"Whereas little, if anything, has been done by the Veterans' Administration to make the necessary corrections in the medical service of the Veterans' Administration; and

"Whereas because of the failure to correct these very apparent weaknesses and deficiencies, the executive committee of the national rehabilitation committee at its May 1941 meeting in Indianapolis passed a resolution, approved by the national executive committee of the American Legion, that a complete survey be made by the national rehabilitation committee through the Washington office and national field service, of the medical service and related personnel of the Veterans' Administration; and

"Whereas this survey has been made and completed, and report has been made to the executive committee of the national rehabilitation committee; and

"Whereas such report shows that much fine work is being done by the medical service of the Veterans' Administration, but that there also exist certain very apparent weaknesses and deficiencies, and after a complete discussion of the report, and the committee being fully advised: Now, therefore, be it

"*Resolved by the executive committee of the national rehabilitation committee,* That a complete reorganization be made by the Veterans' Administration of its medical service, and be it further

"*Resolved,* That in the process of reorganization of the medical service of the Veterans' Administration the following items of importance be considered: (1) A change in the direction and supervision; (2) coordination and stabilization of all related services; (3) a more liberal delegation of authority to managers of field stations in the administration of the medical program; (4) the improvement of supervisory services of central office to eliminate duplications and the establishment of a new system, group, or otherwise; (5) a revision of the present table of medical organization to provide for the replacement of those presently in the Armed Forces and to increase personnel in facilities where inadequacies now exist, or may develop in the future, based on the individual needs of each station without regard to present ration system; (6) the establishment of an improved system of promotion and transfer of medical and allied personnel based on merit and the dismissal from the service of admitted inefficient personnel, instead of the present policy of transfer and further provision for an adequate retirement basis for aged and disabled personnel; (7) adequate training of specialists in various fields where the need for such specialists appears necessary; and be it further

"*Resolved,* That authority be granted to the standing committee of the national rehabilitation committee to seek the correction of any and all other deficiencies that may become apparent which are not herein listed, and be it further

"*Resolved,* That if satisfactory reorganization correcting the apparent deficiencies, now in existence, is not made within a reasonable time, that the American Legion shall request a complete investigation by the World War Veterans Committee of the House of Representatives; and be it further

"*Resolved,* That this resolution be submitted to the rehabilitation committee of the convention committee of the 1941 national convention for consideration and action."

THE LEGION'S PROGRAM TO IMPROVE VA MEDICAL SERVICE

Following that convention, and during World War II, I am sure you will remember numerous articles published in magazines throughout the country criticizing the medicine in the Veterans' Administration. At the conclusion of World War II, the American Legion appealed for advice and guidance to some of the leading men in the field of medicine, as well as the heads of some of our great medical institutions for the solution of this problem.

As a result of this appeal, and consultations with these leaders and the deans of medical schools throughout the country, the medical advisory group of the American Legion was created and submitted a program to Dr. Paul Hawley, the newly appointed Chief Medical Director of the Veterans' Administraion, for the reorganization of the medical service in the Veterans' Administration.

At this time, I think I should give you the names of those men who served on that Legion medical advisory committee:

Initial Appointees to American Legion Medical Advisory Board, created by resolution 667, national convention, Chicago, November 18–21, 1945:

Col. Leonard G. Rowntree, Medical Research (chairman), Chief of Selective Service, Medical Division (for many years, connected with the Mayo Clinic, and member of the Mayo Foundation).

Maj. Gen. George F. Lull, Deputy Surgeon General, United States Navy,

Rear Adm. William C. Agnew, Assistant, Surgeon General, United States Navy.

Col. Esmond R. Long, AUS, Chief of TB Section, Office of the Surgeon General, United States Army (connected with Henry Phipps Institute, Philadelphia, before and after war service).

Capt. C. Raymond Wells, Dental Corps, United States Naval Research, Assistant Chief of Selective Service, Medical Division, and past president of American Dental Association.

Lt. Col. Louis H. Renfrow, Dental Corps, AUS, executive officer, Selective Service, Medical Division.

Lt. Col. Charles W. Mayo, AUS, Mayo Clinic.

Dr. William D. Stroud, profesosr of cardiology, University of Pennsylvania.

Dr. Winfred Overholser, Superintendent, St. Elizabeths Hospital, Washington, D. C.

Capt. Waltham Walters, USNR, United States Naval Hospital, Philadelphia, chief of surgical section, Mayo, Clinic.

VA MEDICAL SERVICE SECOND TO NONE

As a result of this new medical program, the Veterans' Administration has been able to obtain as consultants many of the leading specialists and finest medical men in our country. In addition to that, through the means of the deans' committee, set up in the medical institutions of learning, personnel have been obtained and courses of training instituted, which have resulted in the finest medicine in any of the public hospitals, not only in this country, but in the world. The stay in general medical hospitals has been reduced by one-third of the time required before the institution of the deans' committee. Cooperation has been obtained from these medical men and institutions solely on the basis of treatment for veterans. Any attempt to divert this medicine to the care of others, in our opinion, is a breach of the assurances given to these men and institutions, when they volunteered to assist in the care of sick and disabled veterans. Further discussion of this medical program has been given by my associates, Dr. Rowntree and Dr. Mayo, in their appearance before this committee.

CONSOLIDATION OF MEDICAL SERVICES UNDER H. R. 5182

I wish to call the attention of the committee to the fact that under the provisions of H. R. 5182, it is attempted to consolidate curative practice, as practiced in the Veterans' Administration, with preventive medicine, as practiced in the United States Public Health Service, together with military medicine, as practiced in the Army, Navy, and Air Corps. I hope an opportunity will be presented for the representatives of these respective phases of medical treatment to be heard.

It is our belief that such a consolidation will result not only in lack of efficiency, but at much greater cost. It has been said that such consolidation would result in preventing duplication in construction of hospitals. It is not necessary, in order to prevent duplication, to set up a new bureau, which is also going to administer those hospitals.

The American Legion recommends the reactivation of the Federal Board of Hospitalization with representatives on said Board representing every phase of hospitals under the jurisdiction of the Federal Government, with authority to transfer from one branch of medicine to another these hospitals, whenever necessity or convenience require. This can be done in the future, as it has been in the past, without setting up any new bureau. This Board certainly could act at less cost and with much greater efficiency without taking away from the present existing agencies the sole responsibility for the care of their separate beneficiaries.

It is our belief that the veterans of World Wars I and II, and of prior wars, who have been trying to bring this Nation to victory and peace have earned their right to a separate agency to administer their rights and to take care of their sick and disabled. We do not believe that the Congress of the United States wants to change its present policy of hospitalization for veterans to conform to the recommendation of the Hoover Commission report, whereby every veteran, irrespective of his disability, will be just another patient. We do not believe that the financial structure of this country is dependent upon effecting economies in the care and hospitalization of our sick and disabled veterans.

Mr. KENNEDY. We appreciate the fact that you have been sitting here since 10 o'clock this morning and it is now 1:25, which is much longer than most of the committees sit on the Hill. I want you to know that all of the representatives of the American Legion deeply appreciate the many courtesies and the patience you have extended to our organization this morning. I also publicly want to thank Mrs. Davis, the clerk of the committee and Mr. Kennedy, the general counsel, for their cooperation in arranging it so that we could present our testimony today, especially in view of the crowded program you have on account of the objections that are being filed.

The CHAIRMAN. I wish to say that when the statements are put in the record I will see that they are sent to every Congressman and to every Senator when we have completed our report.

I do not know of any matter that is of more vital importance in time of peace than the settlement of this question of the health of the American people and what is to be done about it. I think our last experience in this last war and in World War I ought to cause us to do something about it in time of peace. We are honestly seeking to arrive at a solution for doing something for the American people.

I am intensely interested in establishing a Department of Welfare or Human Resources, or whatever you want to call it, under a Cabinet officer, who will report to the President on the State of the general welfare of the American people.

I am certainly happy to have had this testimony here because I do not believe that the medical functions of our Department of Health relative to our children and to those who are receiving benefits from the Government ought to be thrown into some general set-up here unrelated to the service that they must render to those people.

Mr. KENNEDY. May I ask for the record that we be permitted to file an additional statement by Mr. Edward A. Hayes, who is one of the past commanders of the American Legion, and a combined statement by Mr. T. O. Kraabel and Dr. Hyman D. Shapiro?

(The statements referred to are as follows:)

STATEMENT OF EDWARD A. HAYES, PAST NATIONAL COMMANDER, THE AMERICAN LEGION

Mr. Chairman and members of the committee, in discussing the proposed United Medical Administration, which would come into being if H. R. 5182 were to be adopted, the Hoover Commission made the statement that "after all, a patient is a patient whether he is a veteran, a merchant seaman, or in the Army, Navy, or Air Force."

In the effort to secure the dismemberment of the Veterans' Administration, the Hoover Commission and the Citizens Committee for the Hoover Report have used slide-rule reasoning to arrive at their conclusions that the operation of the executive branch of the Federal Government should be upon a strictly functional basis. If the reasoning of these two organizations were carried to the extreme, then there no longer would be unified consideration of the veterans' benefit program. The history of Congress' dealing with the program of veterans' affairs would be discarded. The legislative functions of the Government would be surrendered to those few individuals in the executive branch who believe that they, only they, know what is best for the welfare of our Nation.

I. know that you members of this committee have studied H. R. 5182 in its every detail. I feel sure that you have observed, as I have, that there is nothing in this proposed measure which deals with the question of what effect such a measure as H. R. 5182 would have on the veteran and upon his dependents. On the contrary there is nothing but the cold, calculated thought of how best to accomplish the purpose of establishing a new Federal agency which will glorify the originators of such a scheme.

While the stated purposes of the Hoover Commission were to secure economy and efficiency in the conduct of the Federal Government, we submit that there is neither efficiency nor economy in the proposed United Medical Administration. The proposed H. R. 5182 attempts to take the medical and hospital program out of the Veterans' Administration, to destroy the preventive-medicine program in the United States Public Health Service, to remove military medicine from the Department of Defense, and to take over the medical program in the Canal Zone and of St. Elizabeths Hospital. Therefore the purpose is to make of the resultant combination a smoothly functioning organization to handle all of the programs thus submerged into the dreamer's idea of a master plan called United Medical Administration.

The American Legion is inclined to believe you can't combine military medicine and curative medicine, nor can you combine preventive medicine with the other two to achieve a happy result.

So far as the hospital and medical program of the Veterans' Administration is concerned, we believe that the Congress will not be a party to any action which will break faith with the 19,000,000 of men and women who answered the call to serve the Nation in time of war.

We are fully aware that there is an urgent need for economy in operation of our Government today. The lessons of history take us back to 1933 when economy in Government was also the watchword. We are fearful that the mistakes of that period may be repeated again. That is the reason for our interest in opposing the enactment of H. R. 5182, which we view as the key step to accomplish the dismemberment of the Veterans' Administration.

Our organization is not merely giving lip service when we say that we favor economy in the operation of the Veterans' Administration. The 19,000,000 veterans in this country have just as great an interest in reducing the cost of Government as have other groups of citizens. To say that we favor extravagance in the operation of the Veterans' Administration is to draw an erroneous conclusion.

On that score let us draw your attention to the fact that the Director of the Budget has stated that 96 percent of the money Congress appropriated for veterans flows directly to the veterans in benefit programs. That leaves 4 percent for administrative costs, which is not unreasonable. The Veterans' Administration reports the administrative cost of its operations is 5.09 percent. While 5.09 percent of the appropriation for veterans' benefits is still a large sum, it is submitted that you cannot effect any great economy in that phase of the program unless you are willing to reduce the benefits that flow to the veterans.

Those of us who remember the callous and cold-blooded Economy Act of 1933 can recall the terrible year and 8 days that followed its passage and we cannot

be complacent today. Then, as now, the proponents of economy were promised that the war-injured would not be asked to share in the economy. We hear the same pious words today. Savings, they said then, must be made only in the cases of those veterans who might be said to be enjoying Government generosity.

During that year and 8 days, veterans whose disabilities were classified as non-service-conected were removed from veterans' hospitals. At first, in this gigantic bed emptying, no attempt was made to readjust the veterans or to find other care for them. They were thrown from their beds by the thousands, cast in the streets—most of them not only sick but penniless and without hope.

What happened to the promise not to molest the rights of the war-injured veterans?

Once the Economy Act was on the statute books the promise was violated completely. The compensation of disabled war-injured veterans was whittled to the bone in 1933 and in many cases it was completely eliminated, even for gassed and bullet-wounded war heroes. The suicides mounted. Some simply lost the will to live and died of despair.

The greatest "saving" made under the Economy Act of 1933, during the year and 8 days it took The American Legion to break its back, was in service-connected-disability compensation to the tune of $157,000,000. The late Senator Couzens of Michigan said on the Senate Floor "* * * $157,000,000 were taken out of the hides of the men disabled as a result of the World War."

I think it is unnecessary to remind the members of your committee that the cost of veterans' benefits is a part of the cost of war. It just is not consistent to ask the Congress to renege on them in the security of victory. Nobody likes the cost of war, but before we swallow any more falsehoods let's put some billions of dollars in their proper proportion. If the veterans of World War II had been poorer soldiers so that the war had lasted 6 months longer, the cost of the extended months of the war would have run more than 45 billions of dollars, and the Nation would have found ample credit to meet that cost. That sum, may I remind you, would carry the present veterans' benefit program far along in the next decade.

You are here asked to give your approval to H. R. 5182, the Hoover Commission proposal to create the United Medical Administration. This is to be done in the name of efficiency and economy. Though we can find neither efficiency nor economy in H. R. 5182 we are disposed to look beyond its artful planning to see what is in the minds of those who support its passage.

The most ardent supporter of the Citizens Committee for the Hoover Report is the Chamber of Commerce of the United States. That organization published a booklet titled "A Multi-Billion-Dollar Opportunity" and much of the activity of that organization since the publication of that booklet has been in securing economy and efficiency in the operation of veterans' benefit programs. So far as veterans' benefits are concerned that multi-billion-dollar opportunity must come from the benefits that go to the veteran and his dependents. There just isn't that much money spent on administrative costs.

It is for that and other reasons that we in the American Legion view the situation today as being comparable to that which preceded the operation of the Economy Act of 1933. The propaganda front is artfully preparing your mind and the minds of all Americans for an assault on veterans' benefits.

In recent months a disturbing number of magazine and newspaper articles have been inciting the general public and even many veterans against the appropriations for the Veterans' Administration. The attack appears to be against the VA, but it is against the veteran. And many of the proposed veteran victims are joining the attack since the propagandists know that anybody can be taught to think ill of a Federal agency.

Medical and hospital care in the Veterans' Administration at this time are on a high level. The veteran population is getting the benefit of all that medical skill and science can provide. The truth of this viewpoint is found in the reports of the Hoover Commission. That body says that, without including the hospital and medical program of the Veterans' Administration in the proposed United Medical Administration, such an organization would be a unification in name only. The proposal is to use the hospital and medical program of the Veterans' Administration as a pattern for United Medical Administration. It is the opinion of the American Legion that in asking Congress to destroy the medical and hospital program of the Veterans' Administration, the Hoover Commission would dilute the high standard of medicine and surgery as it is operated in the Veterans' Administration. When you mix a superior quality with an inferior

quality the inferior quality draws down the level. You don't get pure water by mixing pure and impure ingredients.

I think it is appropriate to remark here that when you get high-quality service in a medical and hospital program, such as is now practiced in the Veterans' Administration, you don't achieve that standard by buying inferior skills, inferior equipment, inferior hospital plants.

As to costs of operation the Veterans' Administration hospital program compares favorably with those in your home communities. The patient cost per day, in the Veterans' Administration, is lower than the cost of similar medical treatment and surgery that you get in comparably good hospitals that are operated outside the Federal Government.

There is another danger that the Congress faces today. Perhaps this danger is not inherent in the terms of the bill, H. R. 5182, now before you for consideration. It is, nevertheless, a real and present danger.

As of the end of February 1950 there were approximately 29,000 veterans seeking hospitalization in VA hospitals. The number of those eligible veterans who are applying for hospitalization is on the increase. Contrariwise, the number of beds available for their hospitalization is being decreased through the placement of an absolute ceiling of 131,000 beds on the Veterans' Administration, and through the reduction in force in the medical staffs of the VA hospitals that is necessary because of reduced budget authorizations.

Thus it is that the most serious problem we face today in veterans' medicine is the task of getting adequate care for seriously ill veterans. Under the present Veterans' Administration and the American Legion; the existing VA hospitals are the finest tax-supported hospitals in existence. But there are not enough of them. Meanwhile our State and county mental, tuberculosis, and general medical hospitals are in a shameful state and packed to the rafters.

Over and beyond the provisions of H. R. 5182, I am fearful that this situation will be further aggravated if the dismemberment of VA is accomplished, and if the proponents of the United Medical Administration are placed in the position of establishing whether a veteran, a soldier, a sailor, an airman, or a merchant seaman shall have the highest priority when such groups apply for admission to the hospital beds of the proposed United Medical Administration.

Members of the committee, we leave with you this thought: If H. R. 5182, the bill to create a United Medical Administrition, is adopted, then Members of the Congress should be prepared to assist their States in adopting medical programs that will care for the tuberculous veteran, for the mentally disabled veteran, for the cancer-ridden veteran, and for the veteran who is wracked with advanced arthritis.

The American Legion heretofore has agreed with the Congress that care of the war-disabled soldier, sailor, and marine is a Federal responsibility. These veterans served at the call of the Federal Government. They have a right to expect care in their disabled state from the same Federal Government. The costs of the war disabled are on the cuff. The cash was long ago put on the barrel head to pay for the ships and tanks and guns and planes. The Federal Government should not now break faith with these veterans. But if the Hoover Commission proposals are sound then the individual States should take steps to begin caring for war's disabled. No present alternative seems possible.

JOINT STATEMENT OF T. O. KRAABEL, DIRECTOR AND DR. H. D. SHAPIRO, SENIOR MEDICAL CONSULTANT, NATIONAL REHABILITATION COMMISSION, THE AMERICAN LEGION

These comments pertain to the foreseeable effects of any legislative enactment or Executive order that would remove from the Veterans' Administration its medical, hospital and out-patient services. These observations are based upon experiences gained over the past 30 years as representatives of sick and disabled veterans in the development, presentation, and prosecution of their claims and medical causes, and where the two are of necessity combined. These claims, as this committee well knows, pertain to disability compensation, disability pension, insurance, special awards and benefits.

In the early days after World War I there were several agencies of the Government endeavoring to handle the problem presented by the returning disabled veterans. It is a matter of record which has been recounted innumerable times that the inefficiency and virtual chaos brought about from several agencies with no common cause trying to function to solve this problem challenged the attention of both the President of the United States at that time and the Unied States Congress, to the end that a commission was formed to go into the matter. The

findings of this commission, of which Brig. Gen. Charles G. Dawes was chairman, led up to the enactment by Congress of August 9, 1921, by which the medical services of the United States Public Health Service dealing with veterans, the Bureau of War Risk Insurance and the Federal Board for Vocational Training were combined to form the Veterans' Bureau.

It is also a matter of record that the new arrangement proved effective and met the issue. Later, in his message to Congress in December 1929, President Hoover urged further consolidation of those services to veterans still outside the Veterans' Bureau, viz, the National Home for Disabled Volunteer Soldiers and Pension Bureau, and again Congress agreed by forming the Veterans' Administration by the law of July 3, 1930.

By this step Congress brought all major functions affecting veterans into one agency.

We rise to defend that principle—a single agency to handle veterans' affairs—on the basis of the record the Veterans' Administration has made during the past 20 years. Please note that we defend the principle and the system. At the same time we attest to the American Legion's attitude of constructive criticism that has been and continues to be maintained toward the operation of the Veterans' Administration. This for the purpose of noting deficiencies, inadequacies, and errors as to which we have always frankly taken exceptions and offered suggestions for corrections and improvement.

A careful study of the bill before this committee, H. R. 5182, leads us to these conclusions:

(1) There is a complete emasculation of all medical services within the Veterans' Administration—a real dismemberment of an essential function from the VA.

(2) There is no provision or method by which veterans are to be certified or referred to the proposed United Medical Administration for examination, observation, or treatment.

(3) There is no provision as to the priority or preference accorded the veteran as against seven other groups of beneficaries to be served by the proposed United Medical Administration, despite the fact that certain orders of preference are contained in the organic laws pertaining to veterans.

(4) The proposed changes or arrangement will face insurmountable difficulties and confusion in attempting to provide full and adequate medical service to all types of beneficiaries, male and female, adult and child, in-service, civilian, veteran and nonveteran, and the various types of disease classifications. In our opinion this would result in the nonutilization of many beds in certain wards which would of necessity have to be segregated for special purposes.

(5) No standard, uniform examination form will be sufficient for all of these various beneficiaries for the purpose of serving functions other than purely medical.

To cite the case of how a veteran would fare in this proposed United Medical Administration—it is assumed that the Veterans' Administration would call upon that agency for a medical examination report to determine the extent of compensation, pension, insurance, or one of the many special benefits provided for in the organic acts. The medical officers of this proposed new medical organization would have to prepare a report to meet the definite principles in evaluating the effect of disease or injury peculiar to veterans, as distinct from the requirements of the other services. Experience has shown that even with the employment of highly qualified, specialized medical personnel in the Veterans' Administration, at times the medical reports rendered are found to be inadequate for the purposes required. These factors would be further intensified and complicated if certain specific examinations for specific benefits were not conducted in accordance with the special requirements of the law insofar as they affect veterans. An attempt has already been made by the Federal Bureau of the Budget to have all Government medical agencies utilize a standard medical examination form. This has been tried in the Veterans' Administration and not found to be adequate or workable, and has resulted in much delay and additional expense due to the necessity of requiring further examination and reports to meet specific requirements. Generally, Veterans' Administration employees are familiar with these special requirements; the Army, Navy, and Air Force with theirs. In the event of misunderstanding regarding the specific request by the referring agency, continuing demands will be made upon the proposed United Medical Administration for clarification and amplification of reports.

The other beneficiaries of the medical services all have definite principles in evaluating the effects of disease and injury. The Armed Forces require

examinations to meet physical standards for induction or separation; so does the Coast Guard. Civil-service employees' reports would of necessity have to deal with entitlement to retirement or the possibility of employees-compensation benefits. Other categories of beneficiaries, such as merchant seamen, may have to have reports also dealing with the question of employees-compensation benefits or other reports peculiar to the referring agency.

To carry out the purposes of the various reports required would of necessity mean that there could be no standardization of reports and reduction in the forms required. Instead, there would be confusion, a multiplicity of reports would be required, and the examiners would have to be familiar with and trained in the special requirements of each of the agencies involved. All this would result in the medical officer being tied down with a multiplicity of administrative detail, which produces neither economy nor efficiency, at the expense of the person to be served. In addition, there would be considerable delay in the transfer of requests for examination and the transfer of reports back to the referring agency.

Under the present system of a unified Veterans' Administration a veteran reports to the regional office medical set-up for an examination requested by the adjudication service, usually in the same building. There is available to the medical examiner or examiners the veteran's entire claims folder, containing all of his pertinent medical records from the time of his induction, his military medical records, the records of his private hospitalization or medical treatment, and of the official Veterans' Administration examinations. Thus the medical examiner has before him all available medical data needed to reach a determination for the purposes sought. To insure the availability of all of this material in the proposed United Medical Administration would require the transfer of the essential claims folder to an agency outside of the Veterans' Administration. This would be impractical and may lead to losses, misfiling, and delays in normal procedures of adjudication and of other adjudicative processes.

(6) There is no assurance for the continuance of the high type of medical program now conducted by the Veterans' Administration and featured by the deans committee arrangement and residency training program. Public Law 293, Seventy-ninth Congress, section 14 (b), provides that the Administrator of Veterans' Affairs shall have the authority to establish residencies, etc. H. R. 5182 is particularly silent on this point. At the present time there are approximately 2,500 resident physicians in training in the Veterans' Administration, who form a great reservoir for the Veterans' Administration's recruitment program, in addition to their performing essential full-time medical services. If their positions are eliminated, as appears to be the case in the proposed bill, it would create a tremendous shortage of medical manpower necessary to the staffing of the proposed new agency. Without a residency-training program it is doubtful whether the leaders of medicine would desire to continue with the proposed new medical organization.

The more one studies the proposed legislation the more one is struck by its inadequacies, by its uncertain provisions, and by the lack of real implementation of what the proponents seem to have in mind. There are many features and defects that might be dwelt upon at length. The purpose of this supplemental statement is to point out some of the more weighty considerations that support and form the American Legion policy of a single Federal agency fully equipped with medical and related services to administer the services and benefits to veterans as provided by Congress.

Mr. KENNEDY. I also would like to ask permission and I think your office has already arranged to extend an invitation to Dr. Eli Ginsberg of New York City to appear before your committee at some time convenient to the doctor and your committee.

We also would like your permission at some future date agreeable to you to present additional Congressmen who will testify on our behalf against this bill.

The CHAIRMAN. Congresman Lane could not appear but his statement will be filed.

We will keep you advised as to the continuation of our hearings.

(The following letter and statement was received by the committee:)

THE AMERICAN LEGION,
DEPARTMENT OF GEORGIA,
Atlanta, Ga., March 24, 1950.

Mr. T. O. KRAABEL,
Director, National Rehabilitation Commission,
The American Legion, Washington 6, D. C.

DEAR T. O.: Following up our telephone conversations of March 23 in regard to the veterans hospital situation in Georgia, this confirms the stand of the Department of Georgia in favor of keeping Lawson VA Hospital, Atlanta, in operation in its present status and the acquisition of Oliver General Hospital, Augusta, as a VA hospital, with no push for construction of the proposed new 500-bed VA hospital in Atlanta.

We are certain that both Lawson and Oliver General are needed to take care of veterans in this area, and that any move to cut the medical facilities at Lawson would be false economy indeed. We feel, too, that for the sake of giving medical attention to the largest number of veterans in this area and at the same time emphasizing our stand for reasonable economy in government it would be most advantageous to operate Lawson and Oliver General.

Please keep us advised as to what you and your staff will be able to do to put over this program.

Continued best wishes.

Cordially,

GEORGE HEARN,
Department Commander.

STATEMENT OF HON. EDITH NOURSE ROGERS OF MASSACHUSETTS BEFORE THE COMMITTEE ON EXPENDITURES IN THE GOVERNMENT DEPARTMENTS

Mr. Chairman and members of the committee, I appreciate greatly the opportunity you have given me of submitting my statement concerning the proposal for a United Medical Administration.

Most of you know that for more than 30 years I have been in close intimate touch with veterans affairs and especially with matters concerning veterans hospitalization. From 1917 to 1922 I made repeated tours of inspection of military hospitals in this country and abroad; from 1922 until 1932 I served as the personal representative of three Presidents in care of disabled veterans. This tour of duty took me into every State of the Union in which disabled veterans were hospitalized.

I recite this experience to you to remind you that I have acquired a broad knowledge not only of the requirements of our disabled veterans but also a comprehensive understanding of the quality and extent of the treatment our Government has furnished them.

When I came to Congress in 1925 I became active in the legislative end of veterans affairs, and I have worked diligently to build up the Veterans' Administration hospital and medical system.

It was a long and arduous fight, but I firmly believe, as do each of you who have studied the problem, that today we have in the Veterans' Administration Bureau of Medicine and Surgery one of the most efficient and smooth-working organizations of our Government. Disabled veteran after disabled veteran has told me that the care and treatment he has received in Veterans' Administration hospitals is superior in every way to any other comparable service.

It is not surprising to me that all of the recognized veterans' service organizations, the American Legion, the Veterans of Foreign Wars, the Disabled American Veterans, and the American Veterans of World War II (AMVETS), are unanimous in their opposition to any disturbance of the status quo so far as veterans hospitals are concerned. They are the ones who are vitally interested; they are the ones for whom this fine medical and surgical treatment was established and brought to its present high degree of efficiency.

Today the Veterans' Administration Bureau of Medicine and Surgery is universally hailed by civilian medical leaders as an outstanding medical system. Veterans' Administration hospitals and medical personnel are among the finest in America and thousands of veterans will testify to the excellence of the care and treatment they have received from these services.

Under the proposed plan for a United Medical Administration this efficient organization would be consolidated with most of the large-scale activities of the Government in the fields of medical care, medical research, and public health. The proposal would limit the use by veterans of the Nation's hospital plant established for them by making these facilities available to additional groups, principally armed-service personnel and their dependents, and merchant seamen.

I hope sincerely that this plan will be rejected by Congress. There are many reasons—too many to recite here—why our disabled veterans should not be obliged to take their turn, to take their chances, with Government employees and merchant seamen in seeking hospitalization and medical care.

I thank you again, Mr. Chairman, and reiterate my plea that this plan be rejected.

The CHAIRMAN. The hearing will be recessed now to the call of the Chair.

(Whereupon, at 1:30 p. m., the committee recessed to reconvene at the call of the Chair.)

UNITED MEDICAL ADMINISTRATION

TUESDAY, JUNE 13, 1950

House of Representatives,
Committee on Expenditures in the Executive Departments,
Washington, D. C.

The committee met, pursuant to call, at 10 a. m., in room 1501, New House Office Building, Hon. William L. Dawson (chairman) presiding.

The Chairman. Will the committee come to order?

We have met again to hear further testimony on H. R. 5182, a bill to consolidate certain hospital, medical, and public-health functions of the Government in a United Medical Administration.

We will not read the entire bill, but I will read what it contains. Briefly, the bill would establish in the executive branch of the Government a United Medical Administration, headed by an Administrator, to be appointed by the President, by and with the advice and consent of the Senate; provide for the similar appointment of three Assistant Administrators; provide for employment of necessary personnel, subject to the civil-service laws, rules, and regulations; authorize the Administrator to establish special advisory and other committees and groups; establish an advisory board consisting of the Administrator of Veterans' Affairs, the Surgeon General of the Army, the Surgeon General of the Navy, and the Air Surgeon, or their representatives; and require transfer to the United Medical Administration of the following, such transfers to take effect 60 days after the date of enactment:

(1) All functions and facilities of the Public Health Service, all functions of the Surgeon General of the Public Health Service, and all functions of the Federal Security Administrator in relation to the foregoing.

(2) All Veterans' Administration hospitals and facilities for outpatient services and all pertinent functions of the Veterans' Administration and the Administrator of Veterans' Affairs.

(3) General hospitals of the Army, with a few exceptions, and all pertinent functions of the Secretary of Defense, the Secretary of the Army, and the Surgeon General of the Army.

(4) General hospitals of the Navy, with a few exceptions, dispensaries of the Navy and all pertinent functions of the Secretary of Defense, the Secretary of the Navy, and the Surgeon General of the Navy.

(5) Station hospitals of the Air Force, with a few exceptions, and all pertinent functions of the Secretary of Defense, the Secretary of the Air Force, and the Air Surgeon.

(6) The civilian hospitals in the Canal Zone under the jurisdiction of the Panama Canal and other facilities of the Department of Health of the Canal Zone and all pertinent functions of the Panama Canal and the said Department of Health.

(7) St. Elizabeths Hospital in the District of Columbia and all pertinent functions of the Federal Security Administrator.

The bill would provide, also, for the transfer to the United Medical Administration of the property, records, funds, and personnel relating primarily to the transferred functions; and the assignment or detail to the United Medical Administration of members of the armed services. Section 5 would provide for the establishment in the United Medical Administration of a professional career service to be known as the United Health and Medical Services, set out the qualifications required for appointment therein, and the procedure for such appointment, and so forth, and provide for the appointment of disciplinary boards therein. Section 6 would authorize the President to promulgate schedules and rules governing rates of basic compensation of personnel of the United Health and Medical Services, within the limits prescribed by the Congress. Section 7 would authorize the Administrator to place employees of the United Health and Medical Services in schools of the Army, Navy, and Air Force, and in civil institutions of learning. Section 8 would authorize the employment of personnel on a temporary or part-time basis. Section 9 would abolish the Department of Medicine and Surgery of the Veterans' Administration.

We have with us today as our first witness Mr. John C. Williamson. He is the assistant legislative representative of the Veterans of Foreign Wars.

STATEMENT OF JOHN C. WILLIAMSON, ASSISTANT LEGISLATIVE REPRESENTATIVE, VETERANS OF FOREIGN WARS

Mr. WILLIAMSON. Mr. Chairman, in behalf of the Veterans of Foreign Wars of the United States, I want to express our appreciation for this opportunity to testify on this bill.

The subject matter of this bill has been under study by our national committees and by our last national convention, since the recommendation was first broached in the recommendations of the so-called Hoover Commission.

I would like to present as our expert witness on this subject the director of our national rehabilitation service, who has been associated with veterans' work and with the Veterans' Administration for almost 27 years. Following World War I, he was Director of the Veterans' Bureau, and upon the creation of the present Veterans' Administration he was appointed as Assistant Administrator and was charged with the responsibility for planning the hospital program of the Veterans' Administration. He remained in that capacity until March of 1946, when he resigned to become director of our national rehabilitation service. We believe that he is well qualified to discuss the subject of this legislation, particularly as it pertains to the Veterans' Administration hospital program.

I want to present Col. George E. Ijams.

The CHAIRMAN. Colonel Ijams?

STATEMENT OF COL. GEORGE E. IJAMS, DIRECTOR, NATIONAL REHABILITATION SERVICE, VETERANS OF FOREIGN WARS

Colonel IJAMS. Mr. Chairman and gentlemen of the committee, my name is George E. Ijams. I am the director of the national rehabilitation service of the Veterans of Foreign Wars. I would like to read, if I may, this prepared statement, and then submit myself to questioning on the part of the members of the committee if you so desire.

H. R. 5182 is designed to consolidate certain hospitals, medical, and public health functions of the Government in the United Medical Administration. Under the provisions of this bill all hospitals of the Veterans' Administration, all facilities of such administration for out-patient services to veterans, and all functions of the Veterans' Administration, and the Administrator of Veterans' Affairs in relation to the foregoing functions, would be transferred to the United Medical Administration together with certain hospitals of the armed services, the hospitals of the United States Public Health Service, and certain other hospitals.

This legislation is predicated on the report of the Committee on Federal Medical Services to the Commission on Organization of the Executive Branch of the Government, or the so-called Hoover task force.

During the entire history of the United States of America our Government has provided certain benefits to those who have suffered disabilities in time of war. It has also provided for those who have served honorably, and have later found themselves in need of financial or other assistance which their meager financial resources made it impossible for them to provide for themselves. As our Nation expanded, and as our financial condition improved, the laws enacted for the benefit of our veterans have increased in the scope of the benefits to which honorably discharged war veterans are entitled. Following the War Between the States, the Federal Government for the first time recognized the fact that certain members of the Union forces could not earn a living because of wounds or advanced age, and consequently, domiciliary care was provided for these men. A number of domiciliary homes were erected in the Northern States to which Union soldiers might go when they reached a point in life where they could no longer provide for themselves, or have members of their families provide for them.

With the advent of World War I, and before we entered that conflict, there was created by Congress an organization of the Government known as the Bureau of War Risk Insurance, which organization was authorized to issue marine insurance policies against the ships, cargoes, and crews of American ships entering the war zone. This action was taken by our Federal Government because of the great increase in marine insurance rates of private companies. Following our declaration of war on April 6, 1917, the War Risk Insurance Act was amended to cover insurance and compensation for our armed forces, and also to provide for a plan under which allotments of enlisted personnel might be augmented through a Government allowance to certain permitted classes of beneficiaries.

The Bureau of War Risk Insurance was then under the jurisdiction of the Treasury Department. Hospitalization was also authorized

for the first time for former members of our armed services who suffered disabilities as a result of their service in World War I—this hospitalization to be given in hospitals of the United States Public Health Service. The Federal Board for Vocational Education was authorized to give vocational training and education to men who suffered disabilities resulting in a vocational handicap which prevented them from returning to their prewar vocations.

In other words there were four types of benefits administered by three Federal activities, two of which the Bureau of War Risk Insurance and the United States Public Health were administered by the Treasury Department, and the third, the Federal Board for Vocational Education, being an independent agency.

Claims for compensation and insurance benefits which were administered by the Bureau of War Risk Insurance were predicated upon the man's physical disability, thus necessitating physical examinations prior to the adjudication of the veteran's claim. Claims for vocational training and education, administered by the Federal Board for Vocational Education, likewise required a physical examination and an indication of a vocational handicap. These physical examinations were all made by the United States Public Health Service because the Bureau of War Risk Insurance and the Federal Board for Vocational Education had no medical organization of their own. Requests made upon the United States Public Health Service for hospitalization for service-connected disabilities required certification by the Bureau of War Risk Insurance that the man had a service-connected disability, otherwise he was not eligible for hospitalization.

While we were dealing with only 5,000,000 veterans in those days it can be readily seen that the service rendered to those who applied to the Federal Government for benefits required a terrific amount of coordination between the three departments concerned. This coordination necessitating an exchange of thousands of queries, the searching of thousands of records, and the dispatching of replies took time and the employment of hundreds of clerks. In addition to this huge cost to the taxpayers the loss of time greatly delayed service to the disabled veterans in the granting of benefits including hospitalization.

It must be remembered also that the Bureau of War Risk Insurance was centralized in Washington and had no field offices. Consequently, when a veteran applied to a Public Health Service Hospital for hospitalization or out-patient treatment he was refused such service until his application could be submitted to the Bureau of War Risk Insurance here in Washington for certification of the presence of a service-connected disability. This delay in admitting veterans to hospitals proved fatal in many instances.

Likewise, claims for vocational training could not be acted upon by the Federal Board for Vocational Education until a physical examination had been made by the United States Public Health Service, the report returned to them, and they had found that the claimant was suffering from a service-connected disability resulting in a vocational handicap.

The above describes the picture as I found it when I came to Washington in June of 1919, 31 years this month, Mr. Chairman, immediately after my return from France, and accepted a position with the Federal Government as Assistant Director of the Bureau of War Risk Insurance. The picture confronting us was not a pleasant one.

We had a picture of three Federal departments independently administered and all dealing with essential functions in connection with the claims of the same individual veterans. For the veterans living in the District of Columbia where the headquarters of all these organizations were located the situation was bad enough, but for those veterans residing in other parts of the country the greatest possible confusion existed. The veterans were confronted with a kaleidoscopic administrative set-up which required a veteran who knew nothing about Government organizations to contact at least two Federal departments on any type of benefit to which he was entitled. This unfortunate disorganization so delayed action on claims for benefits, and on requests for hospitalization, that a most deplorable situation developed.

In those days we were dealing with less than 5,000,000 veterans and with only 3 or 4 benefits divided between as many departments which required physical examinations before the Federal Government could act. However, because of the physical separation of the Federal agencies administering these benefits, and the medical agency which has to supply examinations before the benefits could be granted, so much delay occurred in the adjudication of benefit claims that a national scandal developed. Mr. Harding was then President and to correct the unfortunate situation confronting our veterans he appointed Gen. Charles G. Dawes, later Vice President of the United States, as the chairman of a committee to make a thorough investigation and recommendation for the correction of the existing evils. Serving on the Dawes committee were other capable businessmen.

After long hearings and careful personal investigation of the Federal Government departments concerned, the Dawes committee made its report to the President of the United States. A pertinent part of their report read:

> Three distinct and separate governmental agencies without a common authority were created for and are now engaged in executing the laws for the relief of the disabled, namely, the Bureau of War Risk Insurance, the Rehabilitation Division of the Federal Board for Vocational Education, and the United States Public Health Service. The result is that the ex-service person finds it extremely difficult to obtain the prompt, generous, and sympathetic treatment which the Congress and the country intended he should receive. It is apparent that such confusion and inefficiency are the results of the present distribution of responsibility among the three main Government agencies designated by law to carry out the various services to veterans, and the utter lack of central control over these three agencies and such other cooperative governmental departments and bureaus as have been utilized in carrying out the purpose of legislation.

Based upon the above, and other findings set forth in the Dawes committee report, specific recommendations were made as follows:

> That there be created a single agency and that there be transferred to it the Bureau of War Risk Insurance, the Rehabilitation Division of the Federal Board for Vocational Education, and such part of the Public Health Service as was necessary in dealing with beneficiaries of the War Risk Insurance and the Rehabilitation Division of the Board for Vocational Education.
>
> That there shall be at the head of the veterans' agency a Director General responsible to the President for all the activities authorized by law in the three agencies transferred.

The two concluding paragraphs of the Dawes committee report are quite pertinent. They read:

> It cannot be too strongly emphasized that the present deplorable failure on the part of the Government to properly care for the disabled veterans is due in large part to an imperfect organization of governmental effort. There is no

one in control of the whole situation. Independent agencies by mutual agreement now endeavor to coordinate their action but in such efforts the joint action is too often modified by minor considerations, and there is always lacking that complete coordination which is incident to a powerful superimposed authority. No emergency of war itself was greater than is the emergency which confronts the Nation in its duty to care for those in its service and now neglected.

The summoning of this committee by you is an earnest to the country that you are convinced of the vital nature of this problem and that you are determined to secure a prompt and effective solution thereof. The man to whom this important mission is entrusted by you will receive in the performance of his arduous duties the wholehearted and enthusiastic support and cooperation of all veterans and all other patriotic Americans. No Cabinet officer or Assistant Secretary burdened with other duties should be the one to whom the man charged with the welfare of the disabled savers of our country should report. He should report directly to the President. His place should be held in the public esteem as one of the greatest honors that the President can bestow, as the service he can render should be one of untold value to the Nation.

Thus spoke the report of the Dawes committee after a thorough and complete study of the situation and after lengthy personal investigations—and, gentlemen, I would like to emphasize that "personal investigations" and discussions with the responsible officials of the Federal Government and the representatives of the veteran organizations.

The members of the Dawes committee realized they were dealing with a single problem—a single problem, the essential parts of which had theretofore been handled by three different and separate administrative agencies of Government. This problem was the proper care of our disabled veterans. After their thorough investigation the members of the Dawes committee appreciated the fact that prompt, economical, and sympathetic care could not be given unless and until all phases of veteran care were placed under one responsible official.

As businessmen accustomed to administering large organizations handling great volumes of work, the members of the Dawes committee knew the only answer was centralization of control so that the veterans would have to contact only one office instead of three. They also knew that one control of all phases of veteran care was absolutely essential to good service with a close control and coordination of each essential function entering into the granting of all benefits to which veterans were entitled.

The result of the findings and recommendations of the Dawes committee was the introduction and passage of legislation establishing the United States Veterans' Bureau, created by law in the Sixty-seventh Congress, and approved by the President August 9, 1921. Under this legislation actual consolidation took place, thus for the first time bringing together those hospitals and other medical activities of the Public Health Service caring for veterans, the Rehabilitation Division of the Federal Board for Vocational Education dealing with vocational training, and the Bureau of War Risk Insurance which had charge of the adjudication of claims for compensation and insurance benefits.

In addition to the hospitals of the Public Health Service made available through the consolidation under the United States Veterans' Bureau, contracts were made with many civilian institutions where hospitalization could be granted closer to the homes of the veterans than was possible through the utilization of Federal institutions. Following consolidation in the United States Veterans' Bureau complaints were reduced to a minimum and when they did occur one man

was responsible—buck passing ceased and order was brought from chaos.

Having found that a consolidated organization with one-man control of all phases of Government activities having to do with the care of World War veterans simplified the handling of the veteran problem and saved the taxpayers money, it was determined in 1930 to make a further consolidation and to bring under the jurisdiction of one responsible Federal official all phases of Government care for veterans of all wars. Thus, on July 3, 1930, the President approved Public Law 536, Seventy-first Congress, and under the authority of that act he issued an Executive order consolidating and coordinating the Bureau of Pensions, the National Homes for Disabled Volunteer Soldiers, and the United States Veterans' Bureau into a new department known as the Veterans' Administration.

It will be seen from the above that a definite pattern was established under which the numerous laws enacted for the care of our veterans in years gone by creating benefits administered by various departments were gradually brought together under one administrative head. This action was taken in two steps: First, in the creation of the United States Veterans' Bureau, bringing together those activities dealing with World War I veterans and later in the creation of the Veterans' Administration consolidating all phases of veteran care having to do with our veterans of all wars.

It is interesting to note that President Hoover in his State of the Union message in 1929, at the beginning of the second session of the Seventy-first Congress stated:

> I am convinced that we will gain in efficiency, economy, and more uniform administration and better definition of national policies if the Pension Bureau, the National Home for Volunteer Soldiers, and the Veterans' Bureau are brought together under a single agency.

This recommendation of President Hoover's in 1929 placed the hospitals and other medical facilities, then a part of the United States Veterans' Bureau, under the control of the same administrative head who had charge of all other phases of Federal care for veterans, and he did so because in his opinion such action would "gain in efficiency, economy, and in uniform administration."

In spite of our past sad experience when various functions of veterans' care were operated as separate entities of government, in spite of the careful and painstaking study made by General Dawes and his committee of able businessmen and their considered opinion that all phases of veterans care must be under the jurisdiction and control of one responsible executive, in spite of President Hoover's own recommendation and expressed opinion that consolidation of all phases of veterans' care must be centralized under one executive to "gain in efficiency, economy, and in uniform administration," we now find ourselves confronted with a recommendation that we return to the very form of divided responsibility which caused chaos and national scandal many years ago—a form of organization found to be most costly to our taxpayers, and most inefficient in rendering prompt and adequate service to our disabled veterans. The dollar cost and the chaos was great when we had only 5,000,000 veterans to serve. If we again separate essential functions of veterans' care we have 18 or 19 million veterans to serve, we will knowingly invite much greater

costs to our taxpayers and certain disaster in granting benefits to which our disabled veterans are entitled.

General Dawes had personally investigated the situation in the three Government departments dealing with veterans' care; also many of those serving on the Dawes committee had had considerable experience in handling veterans' problems as well as the problems confronting large business enterprises. Unfortunately, former President Hoover could not go into the Hoover task-force reports personally because they covered nearly all the activities of the Federal Government. Consequently, Mr. Hoover had to depend on others to make the study for him. I have great respect for Mr. Hoover as an executive and an able businessman. I feel confident his report and recommendations would have been quite different if he could have gone into the questions involved as General Dawes did, instead of leaving this all-important matter in the hands of persons less qualified.

The first information we had regarding the recommendations of the Hoover task force studying the consolidation of hospitals in a separate department, was an article which appeared in an afternoon Washington newspaper on December 26, 1948. This article outlined a proposed reorganization plan under which the hospitals would be separated from other activities of the Veterans' Administration, consolidated with certain Public Health, Army, and Navy hospitals, and set up in a new Government department.

Appreciating the fact that Mr. Hoover could not possibly go into the details of the matters and thinking he would be glad to receive the comments of persons who had been closely associated with the veteran problem over a long period of years, I wrote Mr. Hoover on the morning of December 27, 1948, as follows:

DECEMBER 27, 1948.

The Honorable HERBERT HOOVER,
Commission on Organization of Executive Branch of the Government,
Washington, D. C.

MY DEAR MR. PRESIDENT: To identify myself, may I remind you that I was appointed Assistant Director of the Bureau of War Risk Insurance immediately after my return from France. After the United States Veterans' Bureau was created by law, I served as its Assistant Director. In 1930 when the Veterans' Administration was authorized, you appointed me Director of the United States Veterans' Bureau for the last year of its existence. In 1931 I became Assistant Administrator of Veterans' Affairs, and served in that capacity until March 1, 1946 when I reesigned to assume the Directorship of the National Rehabilitation Service of the Veterans of Foreign Wars.

Yesterday, I read an article in the Washington Star titled "Waste Charged in Health Set-up; Merger Urged." In that article, a proposed reorganization plan was outlined which contemplates the establishment of a new department to have jurisdiction over all medical and hospital activities of the Federal Government, and to include veterans' hospital and medical personnel of the regional and branch offices, charged with the responsibility of medical treatment and examinations for rating purposes. I was very glad to read that this was merely a proposed plan and which had not yet received your approval. In an effort to be helpful to you in reaching a decision as to whether the proposed plan should be approved, I should like to give you a brief outline of the situation which existed in the old Bureau of War Risk Insurance at the time I came here in 1919.

Both the Bureau of War Risk Insurance and the United States Public Health Service were then under the jurisdiction of the Treasury Department. The Honorable Jouett Shouse, then Assistant Secretary of the Treasury, had administrative jurisdiction over both of these organizations and I believe of several others which were not related to this problem. Mr. Shouse was supposed to coordinate the activities of the War Risk Insurance Bureau and the Public Health

Service insofar as veterans' activities were concerned. When a veteran applied for compensation or insurance benefits, it was necessary to have a thorough and complete physical examination made. Therefore, the War Risk Insurance Bureau had to refer veterans to the nearest Public Health Service hospital for this examination. The veteran activity of the Public Health Service was only one of many. Consequently, this organization did not give preference to veteran examinations, but handled them in a routine manner. In many instances, months elapsed between the examination of the veteran and the time when his physical report was sent to the Bureau of War Risk Insurance for adjudication purposes, and during this period the Bureau of War Risk Insurance was severely condemned because of the delay in the adjudication of these claims.

Similar delays occurred in securing beds for the treatment of veterans in Public Health Service hospitals, and while this was not the responsibility of the Bureau of War Risk Insurance, nevertheless, that organization was merely condemned because of any delays which occurred in securing hospitalization. It was because of the lack of control of the hospital and medical organizations by the Bureau of War Risk Insurance that the United States Veterans' Bureau was brought into existence through congressional enactment, so as to place definite responsibility for all phases of the veteran problem under one man.

It must be remembered, Mr. President, that in those days we were dealing with less than 5,000,000 veterans. Today, we are dealing with more than three times that number. Consequently, if criticism and chaos existed in 1919 because of the lack of definite responsibility for all problems arising out of veteran care, it can be readily seen that the proposed plan of again separating medical care and treatment from other responsibilities of the veteran problem will lead to certain criticism in the handling of this difficult activity of government.

There are many other reasons why the proposed plan would not operate smoothly. In the first place the vast majority of Federal beneficiaries for hospitalization are the veterans of our country who have served in time of war. Then too, as time goes on, the veterans become victims of diseases of age and chronic conditions which are quite different from the hospital cases in Army and Navy institutions where all of your patients are young men, and where they are suffering from acute, rather than chronic conditions. As a matter of fact, when a man in active military service suffers from a chronic condition he is, and should be, released from active military duty.

In reading the list of those making up the committee which recommended the consolidation of all Federal hospitals in one separate department, I did not find the name of one person who has had any background and experience in this work over a long period of years. I believe you will agree, Mr. President, that before the stamp of approval is placed on this proposed plan, you should be armed with facts predicated upon actual experience.

I would welcome an opportunity to discuss this matter with you personally because so many of the matters which I have briefly mentioned above occurred during your administration as President of the United States. I should be glad to make myself available to you at any time of the day or night that you may designate.

Very respectfully,

GEORGE E. IJAMS, *Director.*

About 10 days or 2 weeks later, I received a reply from the former President, thanking me for my communication of December 27, 1948, but making no reference to my suggestion that we discuss the proposal personally before he placed his stamp of approval on the recommendations submitted by his task force. Quite naturally I assumed Mr. Hoover was satisfied with the recommendations made by the members of his task force and that he was not interested in the opinion of one who had spent nearly 30 years as an official of the Bureau of War Risk Insurance, the United States Veterans Bureau, and the Veterans' Administration.

Appreciating the fact as we do that the plan for the transfer of VA hospitals to a separate Government department thus again removing one of the major functions of the Veterans' Administration would bring about a situation similar to the one which existed prior to the

creation of the Dawes committee, and having no other recourse open to us, the Veterans of Foreign Wars at its national convention in Miami, Fla., August 21 to 26, 1949, unanimously passed the following resolution:

RESOLUTION NO. 431, OPPOSING PLANS AFFECTING THE JURISDICTION OF THE ADMINISTRATOR OF VETERANS' AFFAIRS

Whereas efficient administration of veteran benefit laws requires an organization of Government fully equipped to administer all veteran benefits under the administrative control of one responsible official; and

Whereas any other form of administration separating the administration of one type of veteran benefit from the others would not only divide responsibility, but would be turning the pages of history back 30 years to a type of organization which was proven to be ineffective and inefficient when the various benefits were administered under separate control; and

Whereas the present functional type of organization of the Veterans' Administration was created after a thorough and exhaustive study by a presidential commission headed by Gen. Charles G. Dawes, former Vice President of the United States, and other competent and experienced businessmen who realized that adequate service to our disabled veterans could not be given if the responsibility of control were divided, and who recommended that there should be established an organization of Government under one responsible Administrator who would have charge of all phases of veterans benefits; and

Whereas attempts are now being made to again separate the component units of the Veterans' Administration thus taking from the control of the Administrator of Veterans' Affairs the essential medical and hospital functions of the Veterans' Administration as proposed in the so-called Hoover task force recommendations: Now, therefore, be it

Resolved, by the Veterans of Foreign Wars of the United States, in national convention assembled at Miami, Fla., August 21 to 26, 1949, that we do strenuously oppose any plan which would take from the immediate control and jurisdiction of the Administrator of Veterans' Affairs, any of the functions of Government which have to do with the care and treatment of veterans; and be it further

Resolved, That a copy of this resolution be sent to the President of the United States, to the Administrator of Veterans' Affairs, and to appropriate committees and Representatives in the Congress of the United States.

We oppose the separation of hospitals and other medical activities from the other essential services of the Veterans' Administration solely because we know from personal experience through the years that such a separation will be more costly than the present system and will create a situation which will make it utterly impossible to give prompt and sympathetic service in the granting of benefits to disabled veterans. Our position is clearly outlined by the words which President Hoover used in his state of the Union message in 1929, when he said:

> I am convinced that we will gain in efficiency, economy, and more uniform administration and a better definition of national policies if the Pension Bureau, the National Home for Volunteer Soldiers, and the Veterans' Bureau are brought together under a single agency.

It is human to err, but it is indefensible to make the same mistake twice. Therefore, we agree with the above quotation from President Hoover and the recommendation of former Vice President Dawes when he said:

> It is apparent that such confusion and inefficiency are the results of the present distribution of responsibility among the three main Government agencies designated by law to carry out the various services to veterans and the utter lack of central control over these three agencies and such other cooperative governmental departments and bureaus as have been utilized in carrying out the purpose of legislation.

It must be remembered that General Dawes and his Commission made an exhaustive study of the situation after which he stated:

> It cannot be too strongly emphasized that the present deplorable failure on the part of the Government to properly care for the disabled veterans is due in large part to an imperfect organization of governmental effort. There is no one in control of the whole situation.

Let us not make the same mistake twice.

For the above reasons, Mr. Chairman and gentlemen of the committee, we respectfully urge that this committee disapprove H. R. 5182 which would again separate the hospitals and other medical functions from the Veterans' Administration, and return to a type of organization which was known to be costly to the taxpayers and thoroughly inefficient.

The CHAIRMAN. Mr. Lanham?

Mr. LANHAM. Colonel Ijams, you refer to the recommendations of the Hoover task force?

Colonel IJAMS. Yes, sir.

Mr. LANHAM. Were the recommendations of the Hoover task force ever adopted by the full Commission? I did not recall.

Colonel IJAMS. I have no idea, sir. I would like to say that the representatives of the Hoover task force never contacted our office at any time.

The first and only contact I had with them was 6 or 8 months ago, when there was a dinner given at the Shoreham Hotel by the Citizens Committee, and they kindly invited me. Mr. Johnson of the Hoover task force gave this dinner. There were about 30 persons present, I guess. During the dinner I did not have very much to say. Everybody there seemed to be very much for this thing, so I kept strictly quiet until I was asked some questions.

Then there was a young man named McCormick, I think, who was very close to Mr. Hoover, who asked me some questions, and I gave him my best reaction, which was identical with what I have stated here.

After the dinner broke up several others of the Hoover group—that is, the young men employed by this group, came over to me. I stayed there until half past eleven. All the other folks had gone home. And they discussed at great length my reactions to the thing. They said, "Why on earth didn't we have this information?"

Mr. LANHAM. Were those members of the task force?

Colonel IJAMS. They were not; no, sir. They were members of the staff of the task force. They were not task-force members.

Mr. HOLIFIELD. The staff of the Citizens Committee, you mean?

Colonel IJAMS. Yes; the staff of the Citizens Committee.

Mr. LANHAM. They, I believe, did approve the plan. The Citizens Committee has publicly approved the plan.

Colonel IJAMS. As far as I know, they have, sir.

Mr. LANHAM. Mr. Holifield can probably answer the question I asked as to whether or not the Hoover Commission as a whole had approved the task-force recommendations.

Mr. HOLIFIELD. I cannot answer that.

The CHAIRMAN. They recommended a medical administration.

Mr. WILLIAMSON. Yes; the Hoover Commission accepted the conclusions of the task force.

Mr. LANHAM. That is all, Mr. Chairman.

Thank you, Colonel Ijams.

The CHAIRMAN. I was interested in page 8, where you say:

It is interesting to note that President Hoover in his state of the Union message in 1929, at the beginning of the second session of the Seventy-first Congress, stated * * *—

and then it goes on to make the statement. You then proceed:

This recommendation of President Hoover's in 1929 placed the hospitals and other medical facilities, then a part of the United States Veterans' Bureau, under the control of the same administrative head. * * *

Colonel IJAMS. That is right.

The CHAIRMAN. Did you encounter any opposition in those parts from the various department heads when this consolidation was recommended?

Colonel IJAMS. You mean the department heads within the Government?

The CHAIRMAN. From these three agencies that were to be consolidated into one.

Colonel IJAMS. Oh, yes. The Public Health Service at that time did not like to see a part of their hospital program absorbed in another department. But they didn't fight the thing at all strenuously, because this recommendation had the backing of, or the move was made on the recommendation of, the Dawes Committee. That is the reason I wanted to emphasize the fact that the Dawes Commission went into this thing personally. I was before them at least five times. And I knew General Dawes pretty well as I had served on his staff during the latter part of World War I. Perhaps he called on me more than others, because he knew me so well.

But they went into it very carefully. Now, the Hoover Committee did not; that is, Mr. Hoover himself. I don't know how far his task force went, but they did not contact us.

The CHAIRMAN. You do not believe, then, that the consolidation of the health features of this Federal Government into one administration will make for efficiency and economy, by bringing the hospitals of the Army and the Veterans' Bureau and other public hospitals that are maintained by the Federal Government into one agency? You do not believe that would make for efficiency and economy?

Colonel IJAMS. Mr. Chairman, I would like to confine my testimoney to what the separation of the veterans' hospitals from the Veterans' Administration will do to the rest of that organization, and how it will adversely affect the service on claims of all kinds, vocational training, compensation, insurance, and a thousand and one other claims.

Now, there is one thing. I served as the Veterans' Administration representative on the Federal Board of Hospitalization for a great many years. Unfortunately, the President abolished the Federal Board of Hospitalization about a year and a half or two years ago. I think that was a great mistake. That Board was set up in the Harding administration also, and it had on it the Surgeon General of the Army, the Surgeon General of the Navy, the Surgeon General of the Public Health Service, the Commissioner of Indian Affairs, the head of the Bureau of Prisons, and the Veterans' Administration. There we had on one Board the representatives of every activity of Government who had anything to do with hospitalization or medical care. Our job was to coordinate. For instance, if Secretary John-

son wanted to build an Army hospital some place, we would say, "Now, just a minute. The Veterans' Administration has a hospital under construction just 40 miles from there. Now, why should you build a hospital?"—unless there was a great concentration of troops there—"because the Veterans' Administration will gladly take into its hospital any soldiers or sailors or marines who are disabled in that area, at actual cost." And likewise the Army and Navy hospitals would take veterans into their hospitals.

Mr. HOLIFIELD. Mr. Chairman, may I ask a question, there?

The CHAIRMAN. Mr. Holifield.

Mr. HOLIFIELD. That would presuppose that there would be beds available in the veterans' hospital?

Colonel IJAMS. Oh, yes.

Mr. HOLIFIELD. And that the priority of the veterans would obtain first, before the hospitalization of the regular forces?

Colonel IJAMS. Naturally, in veterans' hospitals the veteran receives priority always. As a matter of fact, most of the Army and Navy men who came into veterans' hospitals were emergency cases. They had been hurt in an accident, or something happened, and they would be taken in anyhow.

Mr. HOLIFIELD. How about sickness?

Colonel IJAMS. If a man had typhoid, or some similar condition, they would take him to any Army hospital.

Mr. HOLIFIELD. So, in effect, your answer there is only a theoretical answer, because in practice, it did not work out. As a matter of fact, is it not true that your Federal Hospitalization Board did not achieve the purpose for which it was set up, which was a coordinated program, because of the divergent intersts of the different departments involved, and their refusal to coordinate their different services?

Colonel IJAMS. Mr. Holifield, I can't agree with you on that. Prior to World War II, it worked beautifully. When World War II came, everything went haywire. For instance, the Veterans' Administration, prior to World War II, had approximately 72,000 beds in operation. The Federal Board of Hospitalization had passed a resolution authorizing the construction of 3,000 veterans' hospital beds per year for 10 years; in other words, bringing the total number of veterans' beds to 100,000. That was to take care of World War I and all prior wars.

Before we got started on the 30,000 beds that we were going to build over a period of 10 years, World War II struck us. Then everything went out the window. The emergency then was in the Army and Navy. We pulled back. We didn't want to use those critical supplies, and so forth.

So we pulled out of the picture and allowed the Army and Navy to go ahead, and the Federal Board approved all of the hospitals requested by the Army and Navy. And, of course, they could not do their job overnight. They had to determine, in the Army, where they were going to have training areas. The desert crowd out there near your State, where they had a huge concentration of men that were preparing to go over to the Pacific and Africa, and so forth, had to have temporary hospitals; only temporary, because they wouldn't be used after the war.

But I did do one thing. General Magee was the Surgeon General when World War II started, and he was followed later by General

Kirk. But while Magee was still the Surgeon General, in fact on the Christmas Eve following Pearl Harbor, at the first meeting of the Federal Board after Pearl Harbor, Admiral McIntire was there from the Navy, and General Magee from the Army, and I said, before the meeting started, "I suppose you gentlemen are going to do the same thing we have always done in this country." They said, "What do you mean?"

I said, "Build hospitals with two beds for one man."

They said, "What do you mean, two beds for one man?"

I said, "The Army and Navy will come along and build temporary hospitals to take care of all of their needs when they know that the Veterans' Administration is going to have to expand its facilities materially in permanent construction after the war. Now, wouldn't it be good sense and save our taxpayers hundreds of millions of dollars, if you build a certain number of your beds in areas where we know we are going to have veterans' beds, and build as many of them as possible of permanent, fireproof construction, and the rest of them temporary? Then, after the war, sometime between breakfast and lunch time, you will pull out the Army and Navy personnel, and we will put in the Veterans' Administration personnel; because every man in that hospital will be eligible to care in a veterans' hospital. We will simply take over between breakfast and lunch time and carry on."

I am glad to say that we prevailed in several places. At Vaughn Hospital in Chicago, built on the Veteran's Administration property, on our insistence, the hospital is being used in its entirety today, and it saved the taxpayers of this country about $20,000,000 because we did it that way. That was also the case with this large hospital down in Richmond, and many others.

But unfortunately, the Chief of Engineers of the Army wouldn't go along with us on a good deal of the permanent construction, because he said it would take too much critical material; although we found it took one-third less critical material to build a multistory building than the one he built at Walla Walla, Wash., which covered 62 acres of ground and had five heating plants in it, when I couldn't buy a boiler for a veterans hopital.

Mr. LAHAM. Well, as a matter of fact, Colonel Ijams, if the Board were still in existence, or if there were some coordinating agency, the President would not find himself in the difficulty that he is now facing about the building of new veterans hospitals.

Colonel IJAMS. That is definitely my feeling, sir.

Mr. LANHAM. And I agree with you thoroughly that there must be some coordinating agency to take care of the disposition of beds in hospitals, and especially construction of new hospitals.

Colonel IJAMS. That worked prior to World War II.

The CHAIRMAN. Then it is not your opinion that this bill will accomplish what you were talking about, that is, to put all Government hospitals under one head?

Colonel IJAMS. Mr. Chairman, too much attention has been directed, in my opinion, to alleged savings, which in my opinion will not take place under a uniform hospital set-up, and too little attention has been directed to the terrible effect of again separating those hospitals from the other phases of Federal care of veterans.

The CHAIRMAN. Is that not the complaint made by every administration or agency when an endeavor is made to consolidate like activities under one head, where anything is taken from it?

Colonel IJAMS. I couldn't say about other Federal agencies. I am interested in seeing that good service is given the veterans. And good service cannot be given the veterans of this country through the Veterans' Administration if you take one of the essential functions of that organization away from the Veterans' Administration and set it up in a new department.

The CHAIRMAN. Would they not still get the service?

Colonel IJAMS. They would get hospitalization. But before they could go into the hospital, this new department would have to again come to the Veterans' Administration and ask for certain information.

The CHAIRMAN. This bill provides for the turning over of all records and personnel, and so forth, necessary to carry out its objectives.

Colonel IJAMS. Mr. Chairman, if you turn over all the records necessary to give proper hospitalization, you would have to send all the claims over, all the C files of these men.

Mr. KARSTEN. And make a duplicate set of files. How many are there?

Colonel IJAMS. There are twenty some million.

Mr. KARSTEN. I had a question, Mr. Chairman.

In your personal contact, when you attended the dinner you mentioned about a year ago, were those with whom you talked aware of Mr. Hoover's previous recommendations, and were they aware of the experience in years gone by?

Colonel IJAMS. No; and they were amazed, and they said, "Why didn't we have this information?"

I said, "Gentlemen, it was available to you if you had sought it." Then I told them that I had written Mr. Hoover the very day after this report came out in the Washington Star and offered to give him additional information.

Mr. KARSTEN. But evidently they were not aware of the previous experience, or the recommendation, at the time they made their proposal?

Colonel IJAMS. No. It so impressed Mr. McCormack that he asked me if he might send one of his assistants down to see me later. And he did. He was in there all day, and I took him to lunch, and we discussed this thing at great length. And they frankly admitted that, had they known in the beginning what they found out later, their recommendation might have been quite different. But, they said, "We are committed, and we are going through with it."

The CHAIRMAN. Mr. Burnside?

Mr. BURNSIDE. I have two questions I would like to ask. One of them is: Do you think it is wise to consolidate the Army, Navy, Marine Corps, and Air Corps hospitals?

Colonel IJAMS. I would hesitate to commit the Veterans of Foreign Wars on that. But I was in the Government for a great many years, and I found that consolidation of similar activities is very beneficial and reduces costs. I assume—and this is only my personal statement—that when consolidation came, over in the Pentagon, they were going to do that. I realize, of course, that there are certain things that the Navy requires that are not common to the Army, and the same with the Air Force.

Mr. BURNSIDE. The reason I asked: I have asked a number of leaders in the Legion, the VFW, and others, and they seemed to think it might be wise to make that kind of consolidation, but they were not in favor of consolidating the veterans' hospitals. And one phase I notice that you especially touched upon—and that I think needs further analysis—is that you have a different type of case in the veterans' hospitals than we have in the Army, Navy, and Air Corps hospitals. Let us take, for instance, after a person gets up in years. We are now using regular hospital facilities, which are very expensive, when we ought to have more of a rest home type of care.

Colonel IJAMS. You are quite right, sir.

Mr. BURNSIDE. And if we use the same type of care that we use for the Army, Navy, and Air Corps, it would be much more expensive than for this other type of care. We have moved rather recently into the use of this other type of care.

Colonel IJAMS. Mr. Burnside, just prior to World War II we were behind in our building program, as we have always been. And when I say "we" I am speaking of the Veterans' Administration; it is hard for me to get away from that. We started something out at Sawtelle, Calif., which you may remember, Mr. Holifield. We had at Sawtelle a large soldiers' home, some 7,000 domiciled men. We had a large general medical hospital called the Wadsworth Hospital. And we had a thousand-bed psychiatric hospital. That was all at Sawtelle. The psychiatric beds don't turn over very fast, as you know.

Mr. BURNSIDE. They do not require as much treatment by the doctors, either, or at least I might say a different type of treatment by a different type of doctor.

Colonel IJAMS. That is right. They don't turn over so fast; but your general cases, your operative cases, and so forth, do.

Well, we had a lot of what we called frozen-bed cases. We had chronic hearts and nephritis cases and things of that kind, men who required hospitalization but did not require constant high-pressure medical care. They might not see a doctor for a week, or they might need a doctor twice in the day. And so, to make beds available in the Wadsworth Hospital, we had just completed some domiciliary barracks, which were fireproof, brand new, and instead of using those for domiciliary care we put hospital beds in there and transferred all of these old chronic cases over to what was an annex to the hospital, with a greatly reduced medical and nursing staff, but a great many orderlies who had to take care of these boys. That thing worked beautifully. It gave us a couple of hundred beds in the Wadsworth Hospital for the quick turn-over cases, which had been frozen.

And then World War II came, and, as I say, everything happened overnight.

Mr. BURNSIDE. Just one further question along that line, Colonel Ijams. What are we doing as to these 16,000 new beds suggested in the last bill, to take care of that type of need, to cut down on cost and give better service to the veterans?

Colonel IJAMS. I have very decided ideas on what could be done. The Veterans' Administration for many years built hospitals in the home communities of a large concentration of veteran population. Then they established at strategic points diagnostic centers, to which the more difficult case was taken for study and treatment. That

plan is no longer in effect in the Veterans' Administration. In other words, it looks to me as though they are trying to make diagnostic centers out of all the hospitals; which is prohibitive in cost. Ninety-eight and a fraction percent of all veterans entering veterans' hospitals were adequately cared for in the hospitals in their home communities, and less than 2 percent had to go to the diagnostic centers. Your psychiatric cases and your tubercular cases are the most pitiful cases today. Those men are refused hospitalization because the beds are not available. These men are a menace to the community. Your TB cases are spreading tuberculosis. Just before Christmas I had two cases brought in to me. Both were World War II boys. They both had young wives, and each of them had two young children. They had active pulmonary tuberculosis. They couldn't get into a hospital anywhere. I finally, through some splendid cooperation on the part of some gentlemen who worked with me for a good many years, got them in the hospital. But the youngster of one of those boys developed tuberculosis.

That is happening all over America. Something must be done. These men are told to go to private institutions but they cannot pay for hospitalization even if they can find beds. The psychiatric case, of course, is a menace, because you never know when that man is going to have a psychotic episode and kill a lot of people, like we recently had up in New York, or in Camden, where two men blew up. Those things are liable to happen anywhere in America. And there are many of those men today locked up in police stations and jails for their own protection and the protection of the public because there are no beds for them. They are told to go to private institutions. They are totally disabled. They can't work. They cannot pay for private hospitalization even if they could get the bed.

Mr. Rich. May I ask a question, right there?

If they can go to a private institution, why cannot the Government pay it, if you do not have a hospital?

Colonel Ijams. If they are not service-connected, sir, under the law it is not possible to pay for care in a private institution. The service-connected case may be put in a private institution at Federal expense if there is no bed available in a Federal institution. And there are many of them in private institutions. Women veterans are the only group who can go to a hospital of their own choice, whether they are service-connected or not, and be paid for by the Government.

Mr. Rich. Well, in order to aid and assist these people, could you not take some that are in Government hospitals, that you can pay for in a private institution, and put them in that institution, in order to get these people into the hospital?

Colonel Ijams. That could be done, of course, but you are going to have great difficulty in getting a bed in a private hospital, because they are all crowded. And your municipal and State institutions are packed to the rafters.

The Chairman. Colonel Ijams, is not your argument an argument for this consolidation? Since there is a surplus of beds in Army hospitals and a lack of beds in veterans' hospitals, why not put them all under the same one head and use those that are available to take care of them?

Mr. RICH. Can they not make some arrangements, for instance, down at Valley Forge?

Colonel IJAMS. That is a splendid hospital, and we would love to see the Veterans' Administration take it over tomorrow.

Mr. RICH. Well, why do they not do it?

Colonel IJAMS. During the Eightieth Congress I appeared before the House Veterans' Committee, and the subcommittee of the Senate Committee on Labor and Public Welfare, as I recall, in favor of the Veterans' Administration taking over the Schick General Hospital at Clinton, Iowa, and the Camp White Hospital at Medford, Oreg. We were strenuously opposed by Dr. Hawley, who had been the Chief Medical Director, and Dr. Magnuson, the present medical director, on the grounds that they couldn't possibly do it; that they were going to go just a few miles away and build new hospitals.

Mr. RICH. Well, why?

Colonel IJAMS. They wanted to build new hospitals just a few miles away near medical schools.

Mr. RICH. Does that not seem ridiculous?

The CHAIRMAN. This bill takes care of that. This bill puts all hospitals under one jurisdiction, placing the responsibility for hospitalization in one head. There are many of those hospitals that were built out on the deserts that now, under this bill, could be used to house those suffering from tuberculosis. And I understand that you have many, many hospitals that cannot now be used that are not now being used by the Army, that could be used by the veterans for the housing of these domiciliary cases of theirs. And it seems to me that this bill would tend to cure the very thing that you are talking about.

Colonel IJAMS. No, sir, Mr. Chairman. You are getting away from that principal thought, there. If you remove one essential function from the Veterans' Administration, you wreck the whole organization.

Now, as far as the individual hospitals are concerned, if they are good hospitals and fireproof or fire-resistant, we would advocate their use as a part of the Veterans' Administration set-up, to take care of the veterans.

The CHAIRMAN. Then you will also have this: You will have the conservation of medical services. They say there is a shortage of doctors. Under this bill, you would have a better chance to use the available medical talent for all functions, for those who get medical care, hospital care, from the Government, veterans, soldiers, sailors, and others. And you could then use your scarce services to better advantage for the good of all.

Mr. HUBER. Colonel Ijams, in your reference to Schick and these other hospitals, you mentioned these temporary hospitals built during the war that could not be used after the war. Are you also aware that there is a great deal of pressure being brought on both the Congress and VA to take over some of these temporary jerry-built hospitals that are not suitable?

Colonel IJAMS. That should never be done under any circumstances.

Mr. HUBER. Is it not true that at the present time pressure is being brought on the Congress and the VA to take over these firetrap structures that were built to serve as temporary hospitals during the war?

Colonel IJAMS. No pressure is being brought by us, because it would have to come through my office, and I would never recommend that the Veterans' Administration take over a firetrap.

Mr. HUBER. I realize that the Veterans of Foreign Wars would not recommend this, but I am speaking of the general pressure and sentiment; some even in Congress, as a matter of fact.

Colonel IJAMS. I think there is; yes. That is because they do not understand the situation.

Mr. HUBER. They say, "The hospital is there, and they staffed it during the war," and they do not take into consideration that the war is now over and the medical personnel are not now available. Was that not also one of the considerations at the time it was proposed that the Schick Hospital be taken over, that the medical personnel might not be available?

Colonel IJAMS. That was one of them, but their principal objection was that it would take something like a million and a half dollars to rehabilitate it. But I think it was rehabilitated for less than 10 percent of that.

Mr. HUBER. And then the proposal was to move the hospital right into the back yard of this clinical area, where the doctors would only have to walk a short distance to treat the patients.

Mr. BOLTON. I want to ask one question, if I may.

The CHAIRMAN. Mr. Bolton.

Mr. BOLTON. Colonel Ijams, I want to see if I have got myself clear. The real gist of your objection is this—is it not—that one department would be rendering aid to the veteran, whereas another one would be determining who is to proceed?

Colonel IJAMS. No, Mr. Bolton. The Veterans' Administration is made up of many activities, each dealing with a separate benefit. Now, practically all of those benefits require a physical examination of the man. When you separate the hospitals and out-patient treatment, there will have to be such an exchange of correspondence and calls to get this information on which a claim is adjudicated that that type of organization will absolutely bog down the rest of the Veterans' Administration. You will have the worst scandal this country has ever seen, in my opinion, if you again separate those hospitals.

Mr. BOLTON. You mean the necessity of examining a patient to see whether or not he shall receive care or not will create a scandal? I do not quite grasp that.

Colonel IJAMS. No, Mr. Bolton. A man comes in and applies for compensation or insurance. The Veterans' Administration cannot do anything about that boy's claim until they receive a physical examination, a current examination.

Mr. BOLTON. That does not necessarily have to be done in the hospital; does it?

Colonel IJAMS. Or out-patient. The Veterans' Administration wouldn't have any medical set-up at all under this bill. So they would have to go to this outside agency and ask them to make an examination of Bill Jones of Towson, Md., we will say. And Bill would have to go over some place to wherever they had a hospital and get his examination.

Mr. BOLTON. Well, he has to go now; does he not?

Colonel IJAMS. But that is under the control of the Administrator, and he can get that examination immediately in the Veterans'

Administration office. But, if he is under an outside agency, it is different.

Mr. BOLTON. I just can't get myself clear on that. It seems to me that here is a department where the hospitals are all consolidated. And you admit in your own argument that that is the most efficient way of operating any department, to have all those functions under one department.

Colonel IJAMS. That is right.

Mr. BOLTON. Then you object to that, because your department determines who goes into that department to receive the care.

Colonel IJAMS. We are talking about two different things.

Mr. BOLTON. That is what I am trying to get clear.

Colonel IJAMS. Now, when the gentleman spoke about the consolidation of the Army, Navy, and Air Force hospitals, they would all be under Secretary Johnson and whatever Surgeon General he put in charge of them. Their job would be solely hospitalization of in-service men. That is one problem.

But the Veterans' Administration is quite different. They not only have that hospitalization problem, but they have a much greater problem in granting benefits which are predicated upon physical examinations, and which they must control to see that that information gets into the adjudicating agency immediately.

Mr. BOLLING. May I ask a question? Or had you finished?

Mr. BOLTON. Go ahead, Mr. Bolling.

Mr. BOLLING. What proportion of these benefits are based on the establishment of service connection?

Colonel IJAMS. Well, you have other things than service-connected cases to consider. A man could get part III benefits, a nonservice benefit, where the person has to have disability, too.

Mr. BOLLING. What proportion, would you say, of the benefits require establishment of service connection?

Colonel IJAMS. I would say 99 percent.

Mr. BOLLING. Require service connection?

Colonel IJAMS. That is right.

Mr. BOLLING. Now, what are the standards for establishing service connection? I mean, for example, suppose I had come up with, let us say, a kidney injury. Suppose I had come up with that 4 or 5 years after the war? What is my situation?

Colonel IJAMS. You would file a claim to secure compensation. The first thing the Veterans' Administration does is to call for your AGO report, or the equivalent if you were in another branch of the service, to see what if any disability you had in service and if that disability was related to a kidney condition. Or if you had something that the kidney condition might be the natural result of, in service, then they would have no difficulty this long after in establishing a service connection. But if there is nothing in the record, and so frequently there isn't, although the medical records in this war were much better than in World War I, we would then have to go back to lay evidence and get in touch with men with whom you served, to see whether you ever had a condition in service. Because many men rather resented going to a doctor. Some put up with a good many disabilities and stayed on duty.

I recall very well one World War I boy. This was many years ago. In those days I had to approve all disallowances. I found out later that somebody else was approving the allowances, so I changed the procedure. But I had to approve all disallowances. There were many of them that came over my desk, and I couldn't go into all of them, but in going through this case, I saw that this boy, who was a mountaineer from down in Tennessee or Kentucky, had left a widowed mother and a wife and three children. Well, that was my exact condition. I had a widowed mother and a wife and three children. And because of the similarity of our situations, I started to dig through his case. This was several years after World War I, and this boy had been in an artillery outfit in France, horse artillery. There was nothing in his AGO report. He was never sick. He was the healthiest man in the world, apparently, according to official medical records. And on examination, on discharge, there was nothing noted.

I got a roster of his battery, and I wrote to the top sergeant and to several of the other duty sergeants and asked if they remembered this boy. I told them I had just gotten word that he had died of a heart condition, and I wanted to see if anybody remembered anything about his service which would indicate that he had a heart condition. Two of the sergeants wrote back in the affirmative, the top sergeant and one duty sergeant. One said, "When we were moving up in the Argonne, we made a forced march at night, and this fellow was always falling behind. They kept bringing him up. So finally, against regulations, I let him take his pack off and put it on the caisson. Then he still fell behind, and we let him hang on to a rope and drag behind. Then later I let him ride on the caisson. And he complained of these severe pains in his chest."

Then I got in touch with other men. We built up a record of service connection under which that widow got $10,000 insurance and compensation for herself and the three children.

Mr. Bolling. I would like to pursue that line of thought. There is no statute of limitations as to the time when you can establish service connection?

Colonel Ijams. We are still getting service connections from World War I, many of them.

Mr. Bolling. What percentage would you say would be handled in the first few years after the war?

Colonel Ijams. That is hard to say, because you do not know how many allowed claims you are going to have after a few more years.

Mr. Bolling. But you have experience from World War I?

Colonel Ijams. You have your war-wound cases. Most of those are easy. In most of those files there are just a few papers. Many World War I cases are quite large. You go down to the Veterans' Administration and you will find one very famous file. There are about six volumes, each one about that high [indicating]. That man had a psychiatric condition, of course, and he wrote to everybody, every day, and he finally got what he was after.

Mr. Bolling. Colonel Ijams, the point I am after is: Is it not reasonable to believe that a substantial majority of service-connected cases coming out of World War II have already been handled on the basis of experience of World War I?

Colonel IJAMS. No; it is not. I would say that your gunshot cases, your battle casualties, have been handled. But your disease entities are things that require a lot of digging.

Mr. BOLLING. Other than with generalities, can you demonstrate the difference between that situation and World War I?

Colonel IJAMS. I haven't the figures with me, of course.

Mr. BOLLING. It seems to me that is an important underlying question in regard to this whole problem, as to how much additional red tape would result from one facility handling all medical care and the other one handling certification based on medical reports. Because if your percentage of cases on into the future can be demonstrated to be a relatively small percentage of the total, on the basis of a good experience factor from World War I, your argument is somewhat mitigated, let us say.

Colonel IJAMS. Let us take the insurance cases, for instance. Under World War I insurance, the man must show he has a total and permanent disability, which in all probability will remain that way. Now, to show that, he must have a physical examination.

World War II is a little different. A man has to be totally disabled over a certain period of time. But that requires also a physical examination. Everything that they do requires a physical examination.

The CHAIRMAN. Are there any other questions?

Mr. RICH. I would like to ask this one question of the witness, and that is: Would we have any difficulty in taking care of service-connected veterans if we did not permit all non-service-connected veterans to be hospitalized in veterans' hospitals?

Colonel IJAMS. You mean would there by a sufficient number of beds, sir?

Mr. RICH. Yes. Would we be able to take care of the service connected?

Colonel IJAMS. You could. You would have a sufficient number of beds already constructed to take care of the now known to be service-connected cases. No one knows how many service-connected cases there will be, because all of the veterans' organizations are securing thousands——

Mr. RICH. Then we could take care of them now if we confined it to service connection.

One other question. What is the reason that we cannot get the Veterans' Administration to open up the hospitals that were closed by the Army, the ones that are efficient and could be utilized, when we do not have hospitals already constructed?

Colonel IJAMS. I think that goes back to the very thing that I stated with regard to the Clinton, Iowa, and the Medford, Oreg., situation. The medical people at the Veterans' Administration today do not want to use those hospitals.

Mr. RICH. Well, why, when we have the hospitals already constructed, and you have the patients to be hospitalized, do they not do it?

Colonel IJAMS. I couldn't answer that, sir. I agree with you a hundred percent, and that is the very argument that I made, that one of these places had already cost the taxpayers 12½ million dollars, and another 8½ million dollars. They were immediately available. The veterans needed them then. But the Veterans' Administration medical people objected very strenuously to it.

Mr. LANHAM. The President has forced them to accept those hospitals in many cases, Mr. Rich. He just ordered them to take over one in Augusta, Ga. They did not want to take it over, but the President issued an order, and they took it over.

Mr. RICH. I think we ought to have some of these medical people examined to find out what the real reason was. It just does not make sense to me, and I have never been able to get the answer on it.

The CHAIRMAN. Thank you very much, Colonel Ijams.

It is certainly of value to us to meet someone face to face who has had such long experience with our disabled veterans.

I have seen your name on publications for many years. And my questions did not necessarily reflect my attitude on this matter.

Colonel IJAMS. Thank you, Mr. Chairman and gentlemen of the committee.

The CHAIRMAN. Gentlemen, we had looked forward to having a most distinguished witness next. We thought we would have with us Harold Russell. You remember him as the well-known star of the motion picture Best Years of Our Lives, and as one of the outstanding veterans of this country. Illness prevents him from being with us. And Mr. Marvin L. Goldberger, who is national legislative director of the AMVETS, will present his statement for him.

Mr. Goldberger? Will you convey to Mr. Russell our regrets over his illness and our sorrow that he could not be with us?

STATEMENT OF MARVIN L. GOLDBERGER, NATIONAL LEGISLATIVE DIRECTOR, AMVETS (AMERICAN VETERANS OF WORLD WAR II), WASHINGTON, D. C.

Mr. GOLDBERGER. Thank you, Mr. Chairman and gentlemen. Mr. Russell asked me to convey his regrets that he would be unable to appear here this morning. He was suddenly taken ill last night, and it was quite a disappointment that he was not able to appear here.

I would like to read his statement to you.

My name is Marvin L. Goldberger. I am the national legislative director of the AMVETS.

AMVETS (American Veterans of World War II), the only congressionally chartered World War II veterans' organization, wishes to thank this esteemed committee for the opportunity to appear here and present the organization's views on the proposed formation of the United Medical Administration under the provisions of H. R. 5182.

Our National Executive Committee, meeting in Washington, D. C., on March 16, 1950, emphatically went on record in opposition to H. R. 5182, and to the creation of a United Medical Administration. Vital phases of our veterans' medical program are at stake in this bill. We must reckon with the serious consequences if the changes are adopted. We are therefore strongly opposed to the bill for the following reasons:

(1) We believe that H. R. 5182 will not effectuate or secure the efficiencies and economies claimed. As for veterans, it will create new delays not existing today in the adjudication of claims and the determination of eligibility for various veterans' benefits and preferences. Such benefits are dependent upon the veterans' service record and the medical examinations, treatments and findings, as well as the hospitalization of the veterans, and such records and findings would have

to be transmitted back and forth between the new agency and the Veterans' Administration before any action could be taken. Further it will create an additional expense due to such duplications of both records and transactions.

(2) It will destroy the hospital organization, and the long experience gained in the treatment of war injuries so painfully built up by the Veterans' Administration, and this would come at a time when both are so desperately needed as proved by the high demand for beds in the Veterans' Administration hospitals.

(3) It will cause confusion on the question of admission for hospitalization by reason of the difference in eligibility requirements for admission in the various government bodies concerned.

(4) It will delay and hinder the admittance of service injured and needy veterans in the hospitals by setting up a system that will require certification by one agency before admission into a hospital controlled by another. Such delay and red tape may be fatal, and in many cases would be insufferable whenever applied to our veterans requiring hospitalization by reason of their wartime service to our country.

(5) Since the bill makes no provision for priority for disabled veterans and since priority cannot be practically effected in such general hospitals by legislation, it will destroy the present existing priority for admission of disabled veterans with service-connected injuries and disabilities.

(6) An additional medical staff would be created by this bill because certification of veterans for hospitalization is impossible without such a staff. It would have the effect of not only creating a new medical staff but require one to be continued to some extent in the Veterans' Administration. Therefore you can see that any possible economies here would be decidedly limited. We do not think any economies would result.

The improvements desired by the Hoover Commission report such as (1) improving the general standard of Federal medical care; (2) providing of central supervision, better management, and reduced costs; (3) promoting the better utilization of available medical facilities and reduce the deficits in skilled medical manpower; and (4) clear indication to Congress of the cost of Federal medical services can be better effected with more efficiency and with greater economies by the following:

The establishment of an interagency commission which could consist of the medical administrators of the Veterans' Administration, the Army, Navy, Air Force, and Public Health, together with a number of people representing the American public. Such a commission could be bestowed with the following powers and duties:

(1) To evaluate procedures, practice costs and efficiencies providing medical services and annually report the recommendations to Congress;

(2) Could allocate sites for hospitals, allocate beds in the various hospitals so as to eliminate insofar as possible the vacant bed situation in the hospitals of one agency where there is an overloading in the hospitals of another, subject to the provisions that the establishment of eligibility requirements for admission to hospitalization shall remain in the agency concerned with the patient. This suggestion would follow very closely the line of the old Federal Hospitalization Board with which the members of this committee are very familiar.

(3) Create minimum standards for all hospitals and qualifications for all professional employees in the Federal hospitalization program.

(4) Develop and maintain a program of intern and resident physicians and for the training of same and for medical research.

Such a program as outlined in the foregoing encompasses all the possible advantages of the United Medical Administration with none of the disadvantages inherent in such a service. We request the permission of the committee to call its attention to a bill introduced by Mr. Teague, of Texas, on May 25, 1950, H. R. 8647, which calls for the establishment of an interagency commission along the general lines as outlined in our report to you.

I happen to have a number of copies of that bill, if you gentlemen would care to look at them, distributing them among yourselves.

We further ask the committee's permission to suggest that the provisions of H. R. 8647 would in a large measure eliminate those deficiencies found by the Hoover Commission in the Federal medical set-up. It would also forestall the disruptive influence inherent in any program based on amalgamation.

Under the provisions of H. R. 8647, the interagency hospital commission could by effective coordination and cooperation achieve much greater economies and efficiencies than are possible under the amalgamation theory of the United Medical Administration. The commission would have the authority for the transfer of a hospital facility from one agency to another and, with the approval of the respective agency, the transfer of personnel and equipment deemed best for the adequate utilization for all Federal hospital facilities. This could be done without harm to the characteristics and skills that the respective hospital programs have developed through years of experience in specific and peculiar fields of endeavor.

AMVETS wish to be placed on record in opposition to H. R. 5182 and to the principle of the formation of a giant new Government bureau to handle hospitalization of all Federal patients. At the same time, AMVETS wish to bring to the attention of this committee our belief that economies could be achieved and efficiency increased if our Federal Government would act favorably on a system of coordination as outlined in H. R. 8647.

The CHAIRMAN. I would like to say to the members of the committee that H. R. 8647 has been referred to our committee. It will be taken up later.

Mr. Holifield?

Mr. HOLIFIELD. In your opinion, why was the Federal Hospitalization Board abolished? What was the main complaint?

Mr. GOLDBERGER. I do not have sufficient background in that particular question. I would like to refer the question to the National Service Director of the AMVETS, Mr. Clarence Adamy, who is present here this morning.

Mr. ADAMY. (Clarence G. Adamy, National Service Director, AMVETS). Mr. Holifield, I am sorry, but I would not be able to answer that question either. That was, as Colonel Ijams brought out in his testimony, as the result of the chaos created by the tremendous influx of new Federal patients. The whole system broke down. And in the establishment of the new program of the Veterans' Administration, and in the military agencies, they abolished it. The particular factors as to its breakdown, I am not familiar with.

Mr. HOLIFIELD. I hope that we have some testimony on the reason for the abolishment of this Federal Hospitalization Board later on, Mr. Chairman.

The CHAIRMAN. I think we will probably get that under this other bill.

Mr. Rich?

Mr. RICH. I would like to ask them, if they know, why we cannot put into effect, if the need is there, the hospitals that the Army has discontinued the use of.

Mr. ADAMY. That is a matter that lies within the jurisdiction of the Veterans' Administration and the Bureau of the Budget, sir. And whereas, as Colonel Ijams indicated, we also have been very much in favor of the Veterans' Administration taking over certain of these hospitals which are well enough constructed to be well utilized, yet the Veterans' Administration has not seen fit to do so.

Mr. RICH. In your survey, how many of those hospitals, and number of beds, could be utilized now?

Mr. ADAMY. I have no such survey, Mr. Rich. I am sorry. I would not know that.

Mr. RICH. Well, you spoke of the ones that were of adequate construction and, probably, location. I would like to get some idea, because I think it is a bad situation that we are in right now, when we are talking about building many, many hospitals at a cost of $22,000 a bed, when we have thousands and thousands of hospitals now that are being closed down. It is just one of the most nonsensical things to me. I would like to get somebody to answer this. I have been trying to find this out. I want somebody that is interested in the Veterans' Administration, or in some of these agencies, or working for this organization, or the Army, to answer as to that. To me it does not make sense at all. If that is the case, why cannot your organization, or some organization, have those hospitals put back into service, and do it at once?

Mr. ADAMY. The thing I would like to call your attention to is that many of these hospitals were built during the wartime period. Those are the hospitals you are talking about.

Mr. RICH. I have learned that. But you have a number that are all right, and that you can use. I do not want any excuses now. You do not approve some of them. Why do we not utilize the ones that can be used, and do it at once?

Mr. ADAMY. I would concur in that wholeheartedly, sir, and I am quite sure that the Veterans' Administration would have that information you desire.

Mr. RICH. Well, I cannot get it there either.

Mr. ADAMY. I have tried, too, sir.

Mr. RICH. I think it is just one of the most deplorable situations. Mr. Chairman, I will have to look to you to do it.

The CHAIRMAN. You are my troubleshooter. Who is it you work with? Mr. Wagner? I will assign you and Mr. Wagner to that task.

Mr. HARVEY. I note that on the last page of your report, in the middle paragraph, beginning with the sentence:

> The commission would have the authority for the transfer of a hospital facility from one agency to another, and, with approval of the respective agency, the transfer of personnel and equipment deemed best for the adequate utilization for all Federal hospital facilities—

you bring up one of the most important problems. Is not one of the big problems, so far as establishing a unified hospital service, coincidental with the requirements for personnel, staffing the veterans' hospital, the Public Health hospital, the service hospitals?

Mr. GOLDBERGER. I don't quite follow the question.

Mr. HARVEY. Well, you speak of transfer of personnel there. You see that word "personnel"?

Mr. GOLDBERGER. Yes. And this interagency hospital commission would have the authority for such transfer.

Mr. HARVEY. Let us get at it probably a little slower and more simply.

What do you mean, there, by transfer of personnel?

Mr. ADAMY. Short periods and acute situations when any one of the involved agencies should have a peculiar situation involving more personnel. Then, through the utilization of this board, it would be very similar to the old Hospitalization Board, and give them authority to make such transfers.

It certainly could not be a long-term program.

Mr. HARVEY. Well, I will grant you even the apparent logic of your argument, on the surface. I am wondering if you also would not be frank enough to admit to me that the inherited red tape that goes with such a thing would be the very thing that would distort any effort made in the way of an emergency effort along that line. You speak of an emergency, of course, probably in terms of a few days.

Mr. ADAMY. All things being equal, in comparison, sir, I would admit there would probably be a good deal of red tape involved therein; but there would certainly be a great deal more red tape involved in the transferring of records and the transferring of certifications of eligibility and in the determinations of eligibility, between foreign agencies, under the administration idea of a United Medical Administration.

Mr. HARVEY. I am not arguing that with you at all. I agree with you on that. But I am saying to you, here, that any theory of transfer of personnel as such, even for an emergency period, while it is good in theory, just would not work in practice.

Mr. ADAMY. Of course, I have not had enough experience to answer that completely. I grant you, sir, that as I recall, immediately after the war there was a good deal of military personnel transferred into the VA, and that worked within the VA program for 2 and 3 years, which was handled, we thought, rather smoothly.

Mr. GOLDBERGER. I don't have the background in service work that my colleague, Mr. Adamy, has, but I realize that although there might be some inherited problems concerning red tape, administrative mechanics could be set up and embodied here in the regulations of the Commission to handle such a thing. And if the Congressman has in mind the question of the extensive periods for transfer, it seems to me limitations could be placed therein.

Mr. HARVEY. Well, what kind of an emergency, under peacetime conditions, could you anticipate?

Mr. ADAMY. As new facilities are made available, the problem of staffing becomes apparent at that time. Of course, in Public Health facilities, you then get back to epidemics and national calamities.

Mr. HARVEY. Is it not true that staffing still remains, even in spite of the tremendous cost of duplication of facilities, the major problem?

Mr. ADAMY. I believe that it is, sir. The Veterans' Administration officials have told us so.

Mr. HUBER. Will the gentleman yield, there?

Mr. HARVEY. I would.

Mr. HUBER. Is it not very possible that as to these hospitals under construction there will be great difficulty in staffing them unless the medical fraternity does foster programs to provide doctors and technicians?

Mr. ADAMY. Surely, Mr. Huber, but I think it is a national problem and not only of the VA, and so on. I think that we as a nation have got to do something to provide more medically trained doctors and technicians.

Mr. HUBER. I am glad to hear you say that.

Mr. ADAMY. I don't think we could make that an integral part of this matter, because the scarcity of doctors is going to be evident in any program that is developed.

The CHAIRMAN. Mr. Lovre?

Mr. LOVRE. Did anyone connected with the Hoover staff contact the AMVETS prior to the time these recommendations came forth?

Mr. ADAMY. No, sir; not at any time prior to that were we asked for opinions or anything in connection with it.

Mr. HUBER. Have you had conferences with the Junior Chamber of Commerce on this? In some cases, some of their spokesmen have asked for the adoption of the Hoover recommendations in toto.

Mr. ADAMY. We have talked to them in the very recent past only. Since we have come up with a different line of regulations, that is what we have talked about.

Mr. BOLLING. If I understand this correctly, your proposal is to establish a commission which would be like the Federal Hospitalization Board, but with broader powers. It would have actually some power to do something, rather than just coordinate on the sufferance of the various component parts of the Board?

Mr. ADAMY. Yes. Exactly, sir. And we realize that we have brought forward only general recommendations. We think that the answer to the problem lies in this general field, and that it is going to take many, many people with a great deal of experience to make the specific recommendations that are going to absolutely work.

Mr. BOLLING. Your feeling is that you could achieve the objectives stated by the Hoover Commission, which you accept, of economy, efficiency, and so on, better through a process of coordination than through a process of consolidation or amalgamation?

Mr. ADAMY. Exactly.

Mr. BOLLING. I would like to make this one comment.

I would like to congratulate the two gentlemen and the AMVETS for their very constructive approach. They are not only against something; they are for something.

The CHAIRMAN. Mr. Burnside?

Mr. BURNSIDE. No questions.

The CHAIRMAN. Mr. Bolton?

Mr. BOLTON. Your real argument against adopting the Hoover task-force recommendation, as I get it, is the dangers of delay and the red tape in certifying to the hospitals. That is your real objection, is it not?

Mr. ADAMY. That is our real objection, sir. Actually, it is the same objection that Colonel Ijams made, that these problems are very real, and our responsibility and our interest lies with the disabled veterans and the men needing the service. We feel there would be a breakdown to the services to the veteran and his beneficiaries under this plan.

Mr. BOLTON. Let me ask this: If the report were adopted, would not this observation made by Mr. Rich in regard to building new hospitals where we already have idle ones have to be corrected, if we had a consolidation?

Mr. ADAMY. Certainly, I image that could be effected.

Mr. BOLTON. Do you not think that should be taken into consideration in this?

Mr. ADAMY. We certainly do, and that is why we have gone further, here, in our recommendations to you, and recommended that we think the same end could be achieved by coordination through a set-up very similar to the old Federal Hospitalization Board, to a greater end, to a greater efficiency than can be achieved by the idea of amalgamation.

Mr. BOLTON. Well, Colonel Ijams, as I understood him, said that that would not work, because you could not get coordination. That has been tried, has it not?

Mr. ADAMY. It was tried, and it proved very successful in the period between the wars, when conditions were more or less static. It showed itself incapable of coping with the tremendous increase in activity. But I don't think that is only true as to the Federal Hospitalization Board, but also as to many agencies throughout the war.

Mr. DONOHUE. Is it true that the Federal Hospitalization Board was done away with in about the year 1928?

Mr. ADAMY. No, sir; the Federal Hospitalization Board was abolished subsequent to the war, a year and a half or 2 years ago, or maybe, more, sir; in the postwar period, at least.

Mr. DONOHUE. Well, were not the present veterans' hospitals brought back under the jurisdiction of the Veterans' Administration during the administration of President Hoover? Was it not on his recommendation?

Mr. ADAMY. Yes, sir. That is true. They were brought under then for the first time. Prior to that time they had been under various agencies, principally the United States Public Health Service. And the medical program of the VA was established at his recommendation and during his administration.

Mr. DONOHUE. Has your organization gone on record against the Veterans' Administration taking over these military hospitals that are being abandoned?

Mr. ADAMY. We have not, sir. We have edited our opinion and position on each of them individually as it came up. Many of the hospitals are too expensive to maintain and are inadequate. So it is not, we felt, a matter for over-all opinion, but as each particular problem came up we tried to express our opinion as to that.

Mr. DONOHUE. Which ones, in your opinion, should be taken over by the Veterans' Administration?

Mr. ADAMY. Mr. Harvey asked that. I don't have a list of all of them. All of those that are permanent, fire-resistant structures.

Mr. DONOHUE. How about the one in Waltham, Mass.?

Mr. ADAMY. I am not familiar with that hospital, sir.

Mr. DONOHUE. Are you familiar with the one over in Pennsylvania?

Mr. ADAMY. The Valley Forge Hospital?

Mr. DONOHUE. Yes.

Mr. ADAMY. I do believe it would be to the advantage of the Veterans' Administration and to the economy of our Government to take over that one. We also felt the same way about the Oliver General Hospital at Long Beach.

The CHAIRMAN. We are certainly grateful for the contribution that you made to this committee. It is entirely wholesome to see young men of this past war coming in and taking an active part and interest in their Government.

I would like to say to the committee that tomorrow we will have with us Dr. Walter Clarke, who is executive director of the American Social Hygiene Association of New York; Dr. David D. Rutstein, of the Harvard University Medical School at Cambridge, Mass.; and Dr. Eli Ginsberg, of the Columbia University faculty, New York, N. Y. So, I am going to ask that we assemble on time, so as to hear these men before the Congress opens, because the rent-control bill is up, and I am sure all of you gentlemen are more or less interested.

We will adjourn until tomorrow morning at 10 o'clock.

(Whereupon, at 11:55 a. m., the committee recessed to reconvene Wednesday, June 14, 1950, at 10 a. m.)

UNITED MEDICAL ADMINISTRATION

WEDNESDAY, JUNE 14, 1950

House of Representatives,
Committee of Expenditures in the Executive Departments,
Washington, D. C.

The committee met at 10 a. m., Hon. William L. Dawson (chairman) presiding.

The Chairman. The committee will come to order.

We are resuming the hearings this morning on H. R. 5182, a bill to consolidate certain hospital, medical, and public health functions of the Government in the United Medical Administration.

We have with us for our first witness today Dr. Eli Ginzberg, associate professor of economics, Columbia University. Dr. Ginzberg is filing a written statement with the committee. He desires not to read the statement, but to comment on a summary of the statement.

Dr. Ginzberg, will you identify yourself for the record?

STATEMENT OF ELI GINZBERG, ASSOCIATE PROFESSOR OF ECONOMICS, COLUMBIA UNIVERSITY

Dr. Ginzberg. Mr. Chairman, my name is Eli Ginzberg; my official position is that of associate professor of economics, of Columbia University. I am also the director of the "conservation of human resources" project, which is being launched by the university.

I am glad to be able to come here today, because of the fact that ever since the early part of the war, in 1942——

The Chairman. May I interrupt you to ask what the title of the project you referred to was?

Dr. Ginzberg. Certainly. I am director of the "conservation of human resources" project, which the university is launching.

I am glad to have this opportunity to appear before your committee today, because of the fact that ever since 1942 I have had a continuing relation with certain aspects of Federal medical services. In 1942, I was the personnel specialist in General Somervell's office and had some supervisory control over medical personnel. I then served as a special assistant to the Director of the Hospital Division in the Surgeon General's office, and then there was a special division created in the second part of the war, which I headed and which was called the Resources Analysis Division. This had responsibility on a staff level for allocating personnel and controlling the facilities of the Medical Department of the Army throughout the world.

After the war I was appointed, by the Secretary of War, as the lay member of the Medical Adisory Board—and I would like to say that I am an economist, a Ph. D.; I am a doctor of economics, but not a physician.

Then after that I became a consultant to the Hoover Commission, to the task force on the Federal medical services, but really worked with them closely only during the first part of their work, because my approach to the problem began to differ with them; that is, with Mr. Voorhees and with the other members of the task force. Many of them were and are good friends, but I could not continue to serve, although the report shows I was connected with them, at the beginning.

In addition to that and the background I have had with medical problems from some other angles, I was the chairman of the Committee the Function of Nursing in New York, and then more recently the director of the New York State hospital study.

The CHAIRMAN. What was that last?

Dr. GINZBERG. That last study was for the purpose of preparing for the State of New York a comprehensive evaluation for the entire hospital situation in New York State. I have also served as consultant to the Group for Advancement of Psychiatry and to the Commission on Chronic Illness.

I have published two books and many articles in recent years on medical problems, although again I point out, from the standpoint of economics; I am an economist.

This morning I would like to take up the approach to this particular bill in terms of four points of view; that is, the background which I think explains why the Hoover Commission and other people are interested in moving in this direction, then a specific analysis of the task force of the Hoover Commission, and then some specific comments on the bill, and, finally, some alternative suggestions.

I think to begin with, Mr. Chairman, there is the need for a realization of the fact that some sixty-thousand-odd civilian doctors who served in the Armed Forces during the war had reason to feel dissatisfied with various aspects of their service.

Many of them complained about being inactive during longer and shorter periods of time, and you will recall that near the end of the war Senator Downey of California, chairman of a special subcommittee in the Senate, investigated this problem of inactivity. To a large extent, in the minds of the civilian doctors in the United States Army, that inactivity resulted from the fact of bad organization. They felt that the Army and Navy were not operating as a unit, as they were not; and they felt that there was a lot of duplication and overlapping in the Army and the Navy Departments.

My own estimate is that probably a better organizational structure during the last war might have cut to the extent of one-fourth the total personnel that was used, or maybe even to the extent of one-third.

Mr. RICH. Will you repeat that?

Dr. GINZBERG. My own rough estimate is that, had there been a better organizational structure of the Armed Forces, the medical departments might have been in position to do a better job and might have done it with between one-fourth and a third less doctor personnel. I make that statement on the basis of the experience that I had as a specialist in World War II, and on the basis of the opportunity that I had to restudy that problem, so that I do not deny that there was justification for many of the civilian doctors in the service to feel that there was something not quite right in the organizational structure.

Mr. RICH. Wherein did the fault lie?

Dr. GINZBERG. I think partly the story was that there were little or no integration between the Army and the Navy at that time; that each unit ran its own complete medical service or system, and, further, according to the organization of the War Department at that time, there was quite a large number of independent medical services set up by the Air Force, the service forces, and by the Ground Force units, and the zone of communication units.

Mr. RICH. You believe that was because of the fact that the Navy used its doctors principally for Navy men, and the Army used its doctors for the men in the Army, and the Air Force used its doctors for men in the Air Force, instead of taking care of the Army, as we term it, of the Air Forces as a unit?

Dr. GINZBERG. I think that was largely the reason for it.

Mr. RICH. You made the statement that we could have saved one-third of the personnel in the Army or in the Armed Forces during the war, and that was the principal reason for it?

Dr. GINZBERG. That is right. However, I think that the civilians who reflected on their experience, including the expert for the Senate committee, Senator Downey's committee, who was an Air Force colonel, come up with a rather naive conclusion. He had come to the conclusion that during the busy days of the Sicilian campaign a doctor might have been busy there one week and could have been attached on the following week to an active unit in the Pacific. That conclusion I think was quite naive, although I think it was quite possible to have made better use and have had better control of the Armed Forces medical personnel.

Mr. HARVEY. Is it not probable that the feeling which the Armed Forces had at that time was that they were looking forward to their probable requirements, and that they had no idea what the casualties might be, and that they realized from the experience of World War I some of the problems, and they wanted to be supplied with adequate medical facilities of all kinds, and they probably overdid it?

Dr. GINZBERG. That existed; yes, I know that might have been the feeling, although there was a certain amount of additional slack. As I state here in my prepared statement, I do not take the position that the services did all that they might have done to use their medical personnel efficiently. I make the estimate that an integrated medical service for the Army and the Navy might have resulted in reducing requirements of personnel by a quarter or possibly even a third; yet, I cannot take too seriously the critical attitudes and the naive logistical solutions outlined by some of the critics. We need not necessarily conclude that the allocation that occurred was particularly bad; at least, there is little evidence to support such a negative conclusion. More nearly the opposite was true. We can come up with the conclusion that at least on the basis of objective measures the allocation made during the war did not necessarily hurt the civilians. There is evidence that civilian health showed continued improvement.

Mr. HOFFMAN. May I interrupt you for a question?

Dr. GINZBERG. Certainly.

Mr. HOFFMAN. You say on page 3 of your statement that, although almost 40 percent of the doctors were withdrawn from civilian life

during World War II, reliable indices of the health of the American people show improvement?

Dr. GINZBERG. Yes.

Mr. HOFFMAN. Where did you get that information? Is that taken from doctors?

Dr. GINZBERG. Yes.

Mr. HOFFMAN. That is not the experience I had in the county where I lived, and this is experience I did not get from books, but I got from people living right in the community.

Dr. GINZBERG. I think if you will get the statistics from a large number of——

Mr. HOFFMAN (interposing). I am not talking about that. I am talking about what happened in my own community during the war where we did not have doctors and we could not get doctors.

Dr. GINZBERG. There was some evidence of that, too.

Mr. HOFFMAN. When there were doctors in the service who were not being used.

Dr. GINZBERG. That is a part of this statement——

Mr. HOFFMAN. Where do you get this statement that the health of the people generally shows improvement?

Dr. GINZBERG. One would have to make use of the objective data of the whole United States. It is very difficult to pick out one community——

Mr. HOFFMAN (interposing). That is what you say here; that the health of the people is better with fewer doctors?

Dr. GINZBERG. You have, in the major indices, two major factors. On the one hand, you have the evidence where people are in better health. And on the other——

Mr. HOFFMAN (interposing). What I am getting at is this: You make the statement that the fewer doctors you have the better off you find the health of the people in the community. Now where did you get any such information, if you did not live in a community where the health was better?

Dr. GINZBERG. I did not say that.

Mr. HOFFMAN. That is exactly what you said.

Dr. GINZBERG. May I read it.

Mr. HOFFMAN. Certainly.

Dr. GINZBERG. Let me read that paragraph.

Mr. HOFFMAN. I read the paragraph on page 3.

Dr. GINZBERG. Could I read that?

Mr. HOFFMAN. Certainly, read it twice if you want to.

Dr. GINZBERG. I would like for you to indicate where that part of it is.

Mr. HOFFMAN. Yes, down in the third paragraph on page 3.

Dr. GINZBERG. "One need not adopt the cynical attitude"——

Mr. HOFFMAN. Start with the previous sentence, about one or two lines back.

Dr. GINZBERG. "Although almost 40 percent of the effective supply of doctors were drawn from civilian life during World War II, the most reliable indices of the health of the American people show improvement, not retardation."

Mr. HOFFMAN. Where did you get the fact that the health was better with fewer doctors?

Dr. GINZBERG. I did not say that. I continued with this statement:

One need not adopt the cynical attitude that the fewer the doctors in active service the better the health of the people, but one must contemplate the possibility that many services that doctors render in normal times are relatively unimportant——

Mr. HOFFMAN. Stop right there. Now what are the services that doctors render that are unimportant?

Dr. GINZBERG. I do not know in your State, but I know my State——

Mr. HOFFMAN. I know my State too. And, I live in a community. Where do you live?

Dr. GINZBERG. I live in New York and also in Maine.

Mr. HOFFMAN. You make your summer home in Maine for vacationing and you are in New York in the winter time?

Dr. GINZBERG. Yes. And maybe I work just as hard in the summer as you do.

Mr. HOFFMAN. I hope you do; you are a younger man. But getting back to this, you say the fewer the doctors we have in a community the better the health of the community?

Dr. GINZBERG. I did not say that.

Mr. HOFFMAN. With all the Government activities, trying to improve the health of the people.

Dr. GINZBERG. I did not say that.

Mr. HOFFMAN. That is exactly what you did say in this last paragraph.

Dr. GINZBERG. No. If you continue on you will see that I make the point——

Mr. HOFFMAN. I have not had an education in logic or in argument, but I do know something about words, and I have read them, and you say that despite the fact that almost 40 percent of the doctors were drawn from civilian life the health of the American people showed improvement.

Dr. GINZBERG. During the war emergency——

Mr. HOFFMAN. Do you have any basic facts to back up the statement that the health was better? You are talking about people in the Army?

Dr. GINZBERG. Well, they were eating better.

Mr. HOFFMAN. That is what you say. I say just the contrary, and I am speaking for the people I know, not from something I get out of books, but something that I got from people right in my own community. Where did you get this information?

Dr. GINZBERG. You know the wrong people; the poor ate better. My information comes, well, from the AMA.

Mr. HOFFMAN. For what period?

Dr. GINZBERG. And from Metropolitan Life.

Mr. HOFFMAN. Can you bring any figures in here to show that the health of the people was better?

Dr. GINZBERG. I will be glad to submit them.

Mr. HOFFMAN. Showing that the fewer doctors the better the health?

Dr. GINZBERG. I never said that.

Mr. RICH. I would like to ask you this question, if the doctors, in the Army, were overworked?

Dr. GINZBERG. The doctors—I think it is inevitable, that during the period of war activity, quite a few were; there were doctors who

were very badly overworked. There were some doctors who never got off their feet, some surgeons who never got off their feet for 40-hour periods at Anzio, during the war, where that was necessary for short periods, and other doctors who were not kept busy.

Mr. RICH. Would you say that normally the doctors who were in the Army were kept busy on the European front?

Dr. GINZBERG. I would say that on the whole yes, I think you could say, that with probably some exceptions—and I am willing to go with Mr. Hoffman as far as saying that you might have had better control, and if you had, you could have saved a fourth or possibly a third of the medical personnel.

Mr. HOFFMAN. I did not say that. I have no objection to it, but my criticism was that when you said that the health of the people was better when we had fewer doctors that you do not know what you are talking about.

Mr. RICH. Maybe some of the doctors gave them too many pills.

Dr. GINZBERG. I do not know about that.

Mr. RICH. If you give some people medicine sometimes they will take too much.

Mr. HARVEY. I think it is also true that a great many of the doctors who were left on the home front were greatly overworked. I know there were a lot of doctors whose lives were made expendable by that work.

Dr. GINZBERG. There is no question about it.

Mr. HARVEY. Their life expectancy was shortened many years because they were the older doctors and because their own physical infirmities made their work even more difficult, and because of that, in many instances, the doctors who were left here, many of them, did two men's work.

Dr. GINZBERG. Let me speak of my own State, because I know the situation more accurately; I am more familiar with the situation there from the hospital study. In the olden days the doctors up-State used to try to treat the patients at home, try to keep them on the farm, and when during the war their time got very short or they did not have time, they brought their patients into the local hospital in order to conserve their own traveling time. Now they have more people using the hospitals in up-State New York than they have ever had before. That has been a complete transformation which has taken place during the period of the war.

Mr. RICH. Is it not a fact today that the hospitals all over the country are being utilized by country people more and more because of the fact that they can get all the services that they need in the hospital while they do not have the facilities at home to give them the scientific treatment that is necessary for the restoration of their health?

I think that people have been educated to that. The only thing that I find fault with is trying to handle the hospital the way they do, the fact that we have all these rules and regulations that are so strict in many States that it makes it difficult for the nurses to complete their training—the local country hospital cannot train its own nurses.

In cities like Philadelphia and Pittsburgh, for instance, through the educational facilities they have, and the fact that Harrisburg makes the requirements so great, and the restrictions almost unbearable, that the local country hospital cannot train its own nurses and

they cannot get nurse attendants, and unless there is some breaking down of some of these high educational rules and regulations we are going to have difficulty. And that is the reason why it is costing us so much in Pennsylvania to have nurses in the country hospitals, because of the rules and regulations that have been laid down, and the demands, so that the practical nurse has no standing.

Dr. GINZBERG. We tried in New York, Mr. Rich—and recently I published a book called A Program for the Nursing Profession, to deal with that very problem—but in New York now we are trying to allow the individual hospitals to solve that problem, by training practical nurses.

Mr. RICH. I am not opposed to their receiving an education, but some of these institutions have demands that are so great that before people can get into the hospital as a nurse they have to be a Phi Beta Kappa, and a graduate from some super college. It took me 35 years to get a B. S. degree.

The CHAIRMAN. Dr. Ginzberg, do you subscribe to the theory that there is a shortage of medical doctors during peacetime?

Dr. GINZBERG. I would say this, that there are undoubtedly areas of the country where they have shortages but this is second-hand knowledge. Because I like to deal with first-hand knowledge let me speak of New York State, since I know it best. I am familiar with the doctor situation from the hospital study, and I would say that by and large we are not short of doctors in New York, but there are substantial sections of the country which are short in personnel. I do not have any question about that.

Now, I would like, if I could, to continue.

Mr. LANHAM. It is a little difficult to follow Dr. Ginzberg when we get off into fields of training nurses and other questions.

Mr. HOFFMAN. The questions that I asked were based on statements found on page 3.

Mr. LANHAM. I wonder if we could not defer the questions until he has finished?

Mr. RICH. We were talking about medical science, and we were talking about Government help, and about nurses to be educated, and about trying to find a way to solve the problem, and see that the thing is done that ought to be done.

Mr. HOFFMAN. Let me ask you this question?

Dr. GINZBERG. Certainly.

Mr. HOFFMAN. Are you in favor of this bill or are you against it?

Dr. GINZBERG. I am against the bill.

Mr. HOFFMAN. You are against the bill?

Dr. GINZBERG. Yes.

Mr. HOFFMAN. You were on the task force?

Dr. GINZBERG. I was an adviser, a consultant to the task force.

Mr. HOFFMAN. Well, over here on page 6 of your statement——

Dr. GINZBERG (interposing). I have not got to that point yet. I would like permission, if I may, to use about five more minutes to develop the argument. If I could do that, I think it would be easier to discuss the other points.

Mr. HOFFMAN. The gentleman talks so fast and he has so many points that it is practically impossible for me to follow him all the way through and to know the points you have covered.

The CHAIRMAN. What page are you on now?

Dr. GINZBERG. I am on page 4.

Mr. HOLIFIELD. He is on page 4.

Mr. HOFFMAN. I know. I have great difficulty in keeping up with the witness, and there are some things I would like to develop as we go along.

Mr. HOLIFIELD. Suppose we let him complete.

Mr. HOFFMAN. All right, I have no objection, and then I will come back. Let him complete without anyone asking him any questions.

The CHAIRMAN. Very well, proceed, Dr. Ginzberg.

Dr. GINZBERG. I think I can conclude very quickly. I think I can summarize this, which simply says that when we got through with World War II, a large number of civilian doctors who had been in active service, felt that the organization, the military part of the medical service, had not been functioning properly. I think that was in part justified, but also a narrow point of view, although I think a better organization could have reduced the waste to some degree.

Now, in part two of my presentation I would like to take up four bases of the task force, as to why they are in favor of the unified medical administration, and to discuss each point very quickly.

The first point is they say it would increase the long-run efficiency of the armed services and be able in peacetime to free doctors from taking care of the sick.

There is no evidence in the task-force report to substantiate that; just an assertion. Dr. Hawley was a very important member, and of course his opinion must be taken into account, but the task force had no other evidence. The former Secretary of Defense reserved his position as a member of the Hoover Commission; he would not go along.

On the second point, the task force took the position if we did not have the United Medical Administration it would not be possible to procure personnel for the armed services. Their position was set forth specifically, and the task force said that the services would need a draft. Now, time has proven them wrong; they overcame the personnel shortage. They did not need the draft, but instead of a shortage of specialists, they have had an excess of specialists and the quantity of care improved rather than deteriorated.

Now, on the third point, that of veterans' aid, the point is very relevant. The task force—it is very hard to know exactly what they are saying—but roughly this, see page 7 of my statement. The task force said that we do not want the Veterans' Administration Hospital system increased any further. They say that if anything more is going to be done by the Federal Government it should be done by giving a little bit of additional aid to the community hospitals. At the same time, the task force recognized that the community hospitals, for the specific types of patients the veterans have, mostly neuropsychiatric and tuberculosis, are grossly inadequate. Only 8 percent of entire patient load of the veterans hospitals in any 1 year are the kind of patients that are treated normally in the community hospital. It would seem the task force was not interested in what happens to the other 92 percent of the veterans type of patient; at least, they have come up with nothing concrete.

It is very dangerous advice to give to the United States Government, at a time when the medical resources locally, in civilian institutions, are inadequate.

Again, let me go back to the State where I am best acquainted with the situation: We have 110,000 patients in New York State hospitals; they are crowded to the gills, and notwithstanding the fact that the hospitals are in fact about 30-percent overcrowded in New York State, they represent perhaps the best mental hospitals in any section of the Nation. Yet we have a necessity for a $150,000,000 program of new buildings. At various points, the task force says to the people of the United States that the Federal Government should not increase its Veterans' Administration beds. That is rather disconcerting.

Now, the task force sought to prove the existence of duplication and waste by indicating there was evidence of a surplus of hospital beds in the Army, Navy, and Public Health Service.

First, a study of the beds reveals that many of these beds were in the cantonment type of buildings, built during the war, which were totally unusable for any long-time planning, and that the Army had cut back its system from 600,000 beds to some 100,000 beds as of 1948, and it is down to about 30,000, or below that now.

So there were a great many points of difference in this bed analysis. It was my disagreement with the task force that caused me to stop doing active consultation work with them.

Now as far as the specific provisions of the bill go, I would like to take them up very briefly.

Mr. HOLIFIELD. While you are on that point may I ask you this question——

Mr. HOFFMAN. I object to interrupting the witness. If we are going to let him complete his statement, let us not interrupt him.

Mr. HOLIFIELD. All right.

Dr. GINZBERG. On the bill before me, I have a series of points that I want to make.

As it is drawn, it would be possible for four laymen, the administrator, and three assistant administrators to be the head of the medical operation, and that would seem rather strange. I think one layman, possibly; but not four.

The second point is that according to the bill, the Advisory Board provides only advice. And, Mr. Hoover, Chairman of the Hoover Commission, and former Representative Manasco, said that if the task force suggestion was put into effect that it would weaken if not destroy military medicine. That is in the minority report that Mr. Hoover himself wrote.

The third point is that the bill does not specifically say whether domiciliary homes of veterans are to be taken over or not. If they are to be transferred, the bill should be amended accordingly.

And fourth, I think this is very crucial: The bill provides that all station hospitals as well as general hospitals of the Army and the Navy are to be taken over, except those on the isolated stations within the continental United States.

I know of no precedent of a Federal agency to try to operate on a military post independently such as is now the plan for military hospitals. There is no historical basis to go on, and it is difficult to imagine

how such a transfer can in effect be implemented, or how a Federal agency could operate independently on a military post. I cannot think how that is going to be accomplished, to have the hospital on a post operated by a nonmilitary agency.

The next point in the bill relieves the Secretary of Defense, the Secretary of the Army, and the Surgeon General of the Army of their responsibility in connection with these hospital transfers or without realizing that these hospitals are used for the training of professional and administrative personnel in military-medical aspects. I do not see how you can relieve the Secretary of Defense of that responsibility. And I want to impress upon you again that Mr. Forrestal reserved his position, and refused to vote on this at that time.

There is some discussion in the bill, in section 4, to the effect that there may be certain overage of personnel as a result of the transfers. But Mr. Hoover and Mr. Manasco pointed out that the solution offered by the majority may lead to a reduction in the ability of the Armed Forces to interest doctors to come on active service. And I would say, after some 8 years of experience in this field, that there is no question in my mind, that if the bill went through, that the proposal would reduce the recruitment power of the armed services not only for specialists, but for all doctors.

Finally, I have some alternative approaches to strengthening the Federal medical service. And I think that they can be improved. I do not think the present situation is ideal. Mr. Hoover said this United Medical Administration would involve a revolutionary change. That is his term, not mine. I am saying it would be unfortunate to have a revolutionary change, unless the situation is very bad.

I do not think the present status is very bad. I think that when we realize that since 1948 it has become greatly improved, and that one of the troubles in 1948 was that one did not yet have the Defense Department but only the Defense Establishment, and the Secretary of Defense was unable to bring the Army, the Navy, and the Air Force together the way he wanted to. Mr. Forrestal began to unify them and Secretary Johnson has continued, and thus, one big area of duplication and overlapping I believe is now being brought under control.

The second point is I think that there has been informal liaison between the Army, the Navy, and the Medical Departments of the Veterans' Administration and the Public Health Service, but I think there would be a point to getting some formal control mechanism so that it would be possible to have the fullest exchange in the utilization of the facilities and personnel of the major Federal agencies. I think that is important.

But the most important shortcoming at the present time that I see, and I will say that the task force of the Hoover Commission has correctly recognized it, is the absence of a top level planning agency that would be in position to foresee future needs and determine the best way to meet them. The Federal Board of Hospitalization, now defunct, failed to perform this essential mission. And, the Bureau of the Budget has likewise failed to fill the gap since that Board ceased to operate. Such a top level agency, to discharge properly its responsibility, would have to concern itself not only with the Federal medical

services but also with the impact of the actions of the Federal Government on the civilian sectors.

The establishment of such an agency, in my opinion, is a matter of the highest priority. I think it is important, therefore, to get top level planning so as to have the Federal Government better coordinated with respect to its hospital program.

That is my presentation.

The CHAIRMAN. Mr. Hoffman.

Mr. HOFFMAN. Is it not true that both Mr. Hoover and Mr. Manasco had one object in filing the minority report, and that was that one branch of this organization would not be given authority?

Dr. GINZBERG. No; they suggested just the opposite; they said that if you centralize the authority, Mr. Hoffman, that if the Board was to be advisory only——

Mr. HOFFMAN. Yes; they did not want it advisory only?

Dr. GINZBERG. That is right.

Mr. HOFFMAN. That is what I said; they wanted to give them some authority.

Dr. GINZBERG. Yes.

Mr. HOFFMAN. And this bill does not do that?

Dr. GINZBERG. But your bill follows the majority report.

Mr. HOFFMAN. This is not my bill; it is the Hoover Commission's bill.

Dr. GINZBERG. It was introduced by you?

Mr. HOFFMAN. It was introduced by me, certainly, at their request.

Dr. GINZBERG. I understand.

Mr. HOFFMAN. In fact, very frankly, I know very little about the bill—I wish I knew more—not as much as I should.

Now, you were talking about the health of people being better when we did not have as many doctors, and you suggested that was due to the fact that we did not have as many doctors, or the fact that people were overeating.

Dr. GINZBERG. I said they ate better.

Mr. HOFFMAN. During the war?

Dr. GINZBERG. Yes; there is no question about it.

Mr. HOFFMAN. Where did you live during the war?

Dr. GINZBERG. Many people were eating better.

Mr. HOFFMAN. I am talking about people who live in my community, right out where the people were living. That is where I get my information, first hand; I do not get it out of books, or out of studies, I get it by observation.

Now, did you ever serve in the Army?

Dr. GINZBERG. Was I in the armed services?

Mr. HOFFMAN. Yes; did you ever serve in the Army?

Dr. GINZBERG. I was with the military——

Mr. HOFFMAN. In the Army?

Dr. GINZBERG. No; I was a civilian expert for 4 years.

Mr. HOFFMAN. You never had charge of any business?

Dr. GINZBERG. Business?

Mr. HOFFMAN. Yes.

Dr. GINZBERG. No.

Mr. HOFFMAN. No. What have you been doing; just writing books, and things like that?

Dr. GINZBERG. I ran the Logistics Division for the Surgeon General.

Mr. HOFFMAN. For the Government, under someone else, and you had people below you; is that right?

Dr. GINZBERG. I was in the Government service.

Mr. HOFFMAN. Now, did the task force recommend, in general, this bill?

Dr. GINZBERG. Yes, in general.

Mr. HOFFMAN. And you were in the minority?

Dr. GINZBERG. I was a consultant to the task force.

Mr. HOFFMAN. And, in fact, you quit because your views did not coincide with the task force?

Dr. GINZBERG. I never voted; I was a consultant.

Mr. HOFFMAN. Did you not say awhile ago, during the course of your direct statement, that you quit because you did not go along with some of the views of the task-force members?

Dr. GINZBERG. Yes. The task force could ask my advice or not ask. I was a consultant.

Mr. HOFFMAN. Yes. Then you said a moment ago, did you not, that you quit because you did not go along with some of their views?

Mr. GINZBERG. For a time——

Mr. HOFFMAN. You resigned, you mean?

Dr. GINZBERG. There was no resignation.

Mr. HOFFMAN. No formal resignation. But you did not agree with them?

Dr. GINZBERG. With the final report.

Mr. HOFFMAN. And now you are coming in and certifying that the task force is wrong?

Dr. GINZBERG. Yes.

Mr. HOFFMAN. You mean you voted against it?

Dr. GINZBERG. I never voted; I was not a member; I was a consultant. For the record I want to state that Mr. Voorhees gave me an opportunity to present my point of view to the task force. But I did not convince them.

Mr. HOFFMAN. Now you referred to this man Hawley?

Dr. GINZBERG. Dr. Hawley.

Mr. HOFFMAN. Who is Hawley?

Dr. GINZBERG. Dr. Hawley was the Chief Surgeon of the European medical operations under General Eisenhower, and was General Bradley's assistant in the Veterans' Administration.

Mr. HOFFMAN. He was in the Medical Corps of the Army how long?

Dr. GINZBERG. Oh, about thirty-odd years.

Mr. HOFFMAN. He ought to know something about it?

Dr. GINZBERG. He certainly should; he has a very peculiar, but a very definite view.

Mr. HOFFMAN. Very peculiar?

Dr. GINZBERG. Yes.

Mr. HOFFMAN. And you do not agree with him?

Dr. GINZBERG. I agree that he is a good medical man.

Mr. HOFFMAN. But you do not agree with his suggestions?

Dr. GINZBERG. No.

Mr. HOFFMAN. And you just came to that conclusion because you do not agree with him?

Dr. GINZBERG. Well, there are many people. I know he has a very strong belief in his views.

Mr. HOFFMAN. That is your conclusion?

Dr. GINZBERG. Yes.

Mr. HOFFMAN. After having some 30 or 40 years experience, yet you feel that your views rather than his should have been adopted?

Dr. GINZBERG. No. I think if you will talk to about 500 members of the Regular Army Medical Service, as I did, of which he happened to be one very important member, you will find he happened to be a minority.

Mr. HOFFMAN. Of the medical group?

Dr. GINZBERG. Yes; some 499 other members——

Mr. HOFFMAN. Are opposed to his views?

Dr. GINZBERG. Yes.

Mr. HOFFMAN. Will you just send us a list of them?

Dr. GINZBERG. Well, I think that the Surgeon General of the Army ought to come up and testify.

Mr. HOFFMAN. Well, if the basis of your experience is the same as the basis of your previous statement, that the people are better off with fewer doctors, I think I will just let it stand at that.

Dr. GINZBERG. Very well.

Mr. HOFFMAN. That is all I care to ask.

The CHAIRMAN. Mr. Holifield.

Mr. HOLIFIELD. Dr. Ginzberg, you gave some statistics on the number of beds that were in the United States agencies, and you disagreed with the statistics. I believe the numbers given were 600,000 and 100,000?

Dr. GINZBERG. Yes; for the Army.

Mr. HOLIFIELD. One fault which I have found in talking about hospital beds, also with the Veterans' Administration, is that they quote the number of beds without any relationship to whether the beds are what I would call active beds, in other words, attended by nurses and doctors. That is one of the greatest mistakes they make, I think; and in California, for instance, they say that they have several hundred beds when they will only have a hundred of them in operation. They will quote the number at 600 when actually the numbers of available beds for veterans in that hospital are only 50 or maybe 100 beds attended by doctors and nurses, so that hundreds of beds are not available, so far as their effective use is concerned.

Dr. GINZBERG. I think, at the present time, there is no question, Mr. Holifield, that there is some confusion in the minds of most people who deal with the statistics. And here I am talking in an area in which I have had many years of experience.

For a large part of these beds which the Hoover Commission task force came up and found as being available, when broken down, one found that there was no staff available and there was no use being made of them at that time; that they had been used during the war.

At the present time the Army is using just enough personnel to take care of its patient load; and in New York State there is enough personnel to take care of the hospitals' requirements, and the last time I looked at the Veterans' figures there were about 5,000 to 6,000 beds in veterans' hospitals where there was no personnel available and they could not put patients in them.

Mr. HOLIFIELD. For all practical purposes those beds were not in existence and should not have been used for statistical purposes?

Dr. GINZBERG. That is correct.

Mr. HOLIFIELD. In California we have a hospital at Corona, a naval hospital, which if I remember correctly, has something like 2,000 beds, but which is closed now, yet they use it, for statistical purposes, as being a Government hospital, call it Government beds available. And at the same time we have 1,100 neuropsychiatric cases in other institutions, in State and county institutions who should be in Veterans' beds.

Dr. GINZBERG. One of the things the task force came up with was the question of where we are going if we keep on building Federal hospitals.

Now, they found 5,000 beds that were not staffed. I think part of the trouble is due to the location of the hospitals. I believe you can staff Veterans' hospitals, and I believe you can staff any hospital when the buildings are well located. I think if you go out into the farming regions you will have trouble staffing hospitals.

Mr. HOLIFIELD. You brought up another suggestion: You have suggested that there be some formal coordination of the top planning policy agencies. Do you visualize something similar to the Federal Hospital Board which was abolished?

Dr. GINZBERG. No, I do not. I had an opportunity during the war to see some of that Board's operations, and I do not think it was an effective Board.

Mr. HOLIFIELD. That is one of the things I would like to have your testimony on. Why was it not effective?

Dr. GINZBERG. Well I think the chief reason, probably was that the people who were going to benefit by the decisions of the Board were the people who were deciding on the evaluation. So the tendency was to break down into a logrolling set-up. That was perhaps one reason. Someone would say, for instance, "You agree with me on this and I will agree with you on that."

And a second point is I do not think that such a Board ought to be, really, staffed with Federal agency people exclusively. I think it should have the advantages of what we learned during the last war. Some outside personnel who do not depend for their job, on the agency of which they are a part should be included.

Mr. HOLIFIELD. You made a point about the composition of the Board. Do you suggest that the Board be completely divorced from the agency heads, as far as policy determination is concerned?

Dr. GINZBERG. I think it would be well worth the Federal Government's effort, since it is expending in the neighborhood of—depending upon whether you take the construction cost in the annual budget into consideration between three-fourths of a billion dollars, or 1.5 billion dollars a year in this operation—that it would be worth while for it to have some group of experts, kept in session full time. When they set up the old Board, it never had to deal with any such program as we have under consideration, or any such problems. I do think it would be worth while to have an independent board to be available to advise all agencies.

Mr. HOLIFIELD. The Teague bill, which has been introduced, requires that the Board should be composed of the Surgeons General of the Army, the Navy, the Air Force, the Public Health Service, and the medical head of the Veterans' Administration, and four individuals from outside. In other words, there could be a combination of an outside group and the representatives of these agencies. Do you think

that would be as practical and workable a type of board as the type you suggest?

Dr. GINZBERG. I think the smaller and the more full time the group——

Mr. HOLIFIELD. And the more divorced?

Dr. GINZBERG. The more divorced from the Departments.

Mr. HOLIFIELD. The better off?

Dr. GINZBERG. Yes. And I would go further to say, and I think it is quite important, to remember that the Federal Government gets into the hospital picture through the Hill-Burton Act, and that you have some civilian members——

Mr. HOLIFIELD. But, the Public Health Service is to take care of that, is it not?

Dr. GINZBERG. But I think there are problems in connection with the Hill-Burton law which could have repercussions on the civilian sector.

Mr. HOLIFIELD. Do you have any other suggestions as to how we can solve this hospitalization problem?

Dr. GINZBERG. Well, I think the Bureau of the Budget could bring out a proposal for a more effective coordinating agency, probably by some formalizing of the present set up, by having a representative of the United States Public Health Service, the Veterans' Administration, and the Department of Defense sit on a board——

Mr. HOLIFIELD. There was such a board, as I understand, an informal board.

Dr. GINZBERG. I think it was informal.

Mr. HOLIFIELD. You think it should be formalized?

Dr. GINZBERG. I think so. And I may say, that I have lost some connections during the last year, on the details of how they are operating here.

Mr. HOLIFIELD. That is all.

The CHAIRMAN. Mr. Lanham.

Mr. LANHAM. I have no questions.

The CHAIRMAN. Mr. Hardy.

Mr. HARDY. No questions.

The CHAIRMAN. Mr. Karsten.

Mr. KARSTEN. Dr. Ginzberg, the bill seems to transfer the medical functions of the Secretary of Defense, of the Public Health Service, etc., to the United Medical Administration.

From your experience, should this Administrator be a medical man, or what ought he to be?

Dr. GINZBERG. Well, according to the bill, he is to have three assistants, none of whom have to be doctors, according to the bill.

Mr. KARSTEN. But it does contemplate the transfer of these functions and also of the Surgeon General's?

Dr. GINZBERG. Yes; the functions, but not the Surgeon General's. And I might say that I am opposed to putting the medical operations only under laymen.

Mr. HARDY. You are opposed to this bill, period?

Dr. GINZBERG. Yes. While I am opposed to the bill I would like to see some changes made if it is to be passed.

Mr. KARSTEN. There is one other question: If it is just an advisory board, and referring to the Surgeon General of the Army, the Surgeon General of the Navy, and the Public Health Surgeon General, what are

these gentlemen going to do if you transfer all of their functions; just sit around and attend meetings?

Dr. GINZBERG. Well they are to have a meeting once a month.

Mr. KARSTEN. Yes. In other words, they would meet 12 times a year?

Dr. GINZBERG. Yes. And I might point out that Mr. Hoover, in his dissent to the original report of the Commission referred to too much power being given to any one administrator.

Mr. HARDY. Is anyone overworked under the provisions of this bill?

Dr. GINZBERG. They would not be.

Mr. HARDY. There is not anyone that would be overworked?

The CHAIRMAN. Mr. Harvey.

Mr. HARVEY. Dr. Ginzberg, in your testimony earlier you gave some reference to some figures, and quoted some figures about the task force, dealing with 8 percent and 92 percent. Will you develop that a little further?

Dr. GINZBERG. I will be very glad to do so.

The task force on the whole failed to distinguish between the kind of patients that the Veterans' Administration takes care of.

Roughly, you can divide the patients into four classes: That is, the ordinary person who goes to the hospital to have his appendix or tonsils taken out. That is a short-time medical, or surgical case.

The largest group of the Federal patients are the neuropsychiatric patients, those who are mentally disturbed.

The next largest single group is the tubercular patients suffering from tuberculosis.

The patients suffering from tuberculosis and the mental patients, constitute more than two-thirds of all of the patients of the Veterans' Administration hospitals.

The fourth kind of patients the veterans have, are those longer-term medical and surgical cases, including those who have lost a limb.

Now if you take all the Veterans' Administration operations and figure them for the entire period of a year, you find that only 8 percent of the accumulated patient days in Veterans' Administration hospitals is accounted for by the patients with a duration of stay of less than 30 days. The bulk of the cases of the Veterans' Administration are the longer term mental, tuberculosis, and chronic cases.

The Hoover Commission recognizes that the civilian facilities in the State systems are grossly inadequate to take care of the additional mental and tubercular and chronic cases.

Again I can say from my experience in New York, which has the largest mental hospital system, that we are something like 30 percent overcrowded at the present time, and the Veterans' Administration is constantly under pressure to move from the civilian facilities, veterans that they now have in the civilian facilities.

Now, I say that when the task force of the Hoover Commission recognizes that the use of community facilities to a large degree are adaptable for 8 percent of veterans, and that the civilian facilities for the 92 percent are now "very inadequate," we are forced to conclude that they were willing to let this 92 percent work out its own solution.

Mr. HARDY. Will the gentleman yield, right there?

Mr. HARVEY. Yes; I will yield.

Mr. HARDY. What is the situation with respect to the availability of community facilities, even for the other 8 percent?

Dr. GINZBERG. That would depend, again on the different parts of the country. I suppose we know over-all, and Mr. Hoffman does not like me to quote general statistics, the voluntary community hospitals, are running in the neighborhood of between 75 and 80 percent full all of the time. That means that in many parts of the country the voluntary community hospitals are very close to their maximum capacity and would be hard-pressed to take additional patients.

However, there are parts of the country where you could find some beds for an occasional patient.

Mr. HARDY. Well, if we could assume that there is ample space to take care of those veteran patients, might it not follow that we really have no need for the Hill-Burton Act?

Dr. GINZBERG. That would be part of the logic. You see, the country is so big that there is a spotty picture on the hospitals, but we know there are a large amount of shortages in many parts of the country.

Mr. Chairman, I don't know whether you would do this, but I wrote three articles on Federal hospitalization, with the background, the current situation, and the policy, and if it would be possible to incorporate them at the end of my official testimony I would appreciate it very much.

The CHAIRMAN. You may file the material, and we will determine that question later.

Dr. GINZBERG. I would appreciate it, because I went into these problems in more detail in those articles, which appeared in Modern Hospital last year.

Mr. HARVEY. May I proceed, Mr. Chairman? I just yielded to Mr. Hardy to ask a question.

The CHAIRMAN. Yes; Mr. Harvey.

Mr. HARVEY. You seem to have done a great deal of work with regard to the statistics of hospitalization. With regard to the mental patients in veterans' hospitals, what is the rate of rehabilitation in these mental hospitals?

Dr. GINZBERG. I went into that problem when I tried to get some help from the Veterans' Administration in connection with the New York State study last year. I think one would have to say that because the situation is still one where only a few years having elapsed since the war, it is very hard to come up with a final answer, where the patients are long-term patients. I think you can say as a general rule, or at least I did, that the Federal Government ought to be proud of the fact that it is probably running the best system of mental hospitals in the country; that is, better than New York State and better than any other large system.

Mr. HARVEY. Do you have any figures, though, Dr. Ginzberg?

Dr. GINZBERG. A figure of what sort?

Mr. HARVEY. On rehabilitation of veterans from mental hospitals.

Dr. GINZBERG. Well, I think you would really have to get the experts from the VA on that.

Mr. HARVEY. What is the figure for New York State?

Dr. GINZBERG. Well we have 100,000 patients on the rolls of the New York State mental hospitals these days, and we manage to put 10,000 of them per annum on what we call convalescent care; that

is, we let them go home for a time, to see if they can stay out, at the rate of about 10,000 a year. So about 10,000 flow out, and we are gaining about 3,000 every year.

Mr. HARVEY. My background of experience in that field shows that of patients committed to hospitals 10 percent will recover if you do not do anything. Then, your record is 10 percent. So all you are giving in New York is custodial care.

Dr. GINZBERG. No; I think we are doing much better than custodial care in New York, though we are not doing what we ought to.

Mr. HARVEY. The psychiatrists tell us that excluding dotage patients at least 30 percent of the patients committed, with good, proper treatment, can be restored.

Dr. GINZBERG. Well, there are a hundred pages in my New York State Hospital report on the subject, and it is really too tricky a question to summarize. You can get off too easily. I devoted a hundred pages to that.

Mr. HOFFMAN. It seems to me that he is consistent with the argument that they are better off without any doctors. I think the figures from Indiana prove it.

Mr. HARVEY. I am really seriously questioning this matter of the care that is required for these long-term patients. I think that we should have some figures as to the rate of rehabilitation in these hospitals, particularly your mental hospitals.

Dr. GINZBERG. Suppose I raise this point with you.

What are your options if we do not give that care? We can't permit them to remain at large and shoot up a whole community, as one did in New Jersey recently.

Mr. HARVEY. Oh, no.

Dr. GINZBERG. So you have to try. My position is very simple about mental care. It is that you have to try, up to the limits of your doctors and other resources, to do as good a job as you can; because the better the job the more will be rehabilitated. Now, the fact is that very wealthy patients, with all the money in the world, and with private doctors, will on occasion not get well. We know that. But as a general rule, if you have better medical treatment and more nurses and better conditions for the patient, more will get well. I don't think it is sensible to hit at a single particular figure.

Mr. HARVEY. You are missing the point, though, Dr. Ginzberg, which I am driving at, which I think is very important. You have stressed the fact, and others have here on the committee, that many of our mental patients are committed to State institutions because there are not enough facilities in our mental hospitals.

Now, it is important from the standpoint of looking at the welfare of the patient, primarily, which is our first interest, as to whether the patients themselves are actually having a better opportunity for recovery in a veterans' hospital.

Dr. GINZBERG. Oh, I am sorry. I missed your point, up to this point.

I would like to say unequivocally that the veterans' mental hospitals, to the extent I am able to assess the evidence, are giving a better level of care and doing more for the veterans than any State system in the United States, including New York State.

Mr. HARVEY. All right. Now, then, to what do you attribute that?

Dr. GINZBERG. I think, by and large, it is attributable to the fact that the Veterans' Administration has gotten from the Federal Government the amount of money, and has leadership to hire personnel, to an extent that the legislatures of the several States have not made the money available. It is not only money, but the organization to do an effective treatment job. And I think you ought to be proud of the fact that you have tried to break through this purely custodial type of treatment for patients in Federal Government.

Mr. HARVEY. That is all.

Mr. BOLLING. Mr. Chairman?

Mr. CHAIRMAN. Mr. Bolling.

Mr. BOLLING. Mr. Ginzberg, I would like to address myself to this last paragraph of your testimony and follow up a little further the colloquy between yourself and Representative Holifield.

You speak of the urgent need for a top-level planning agency, and you indicated to him that you felt it should not be composed, as suggested in the Teague bill, of the various representatives of the Government agencies, but that it should be entirely independent. What size and what composition would you suggest for such a board or commission?

Dr. GINZBERG. Could I say that I think you would always want the representatives of the key agencies at least as an advisory group to such a unit. My concept of this unit would be to have a relatively small staff-level planning agency, which might be as small as three full-time senior people, with adequate statistical and research staff to help them in their work. That is, this is a kind of planning which has to get quite detailed, and where you need quite a large amount of specific knowledge that is worked up carefully. So I would think that if you establish such a top-level planning agency, if you had three people, one with, let us say, major background in Federal-type medicine, one perhaps in the State systems, and one with general civilian medical knowledge, that type of background would be requisite.

Mr. BOLLING. All professionals?

Dr. GINZBERG. Not necessarily all doctors; but professionals, yes, I think so. Or even two professionals. I wouldn't think that all three would have to be professionals.

Mr. BOLLING. In your consideration of it, where would you place such an agency?

Dr. GINZBERG. Well, I think it could, if the Bureau of the Budget wanted to assume responsibility, be put there. I think there are some advantages to not putting it there. And on the other hand, since I know the whole of the Hoover Commission has been interested in reducing the number of people who report to the President, I think you might have to put it in the Bureau of the Budget; but as a special type of unit.

Mr. BOLLING. Now, would it be a board, or a commission, or what?

Dr. GINZBERG. Well, I don't even know the distinctions that you have in mind, really, between "commission" and "board."

I would like to think that these were distinguished people with competence in their field, appointed by the President, with the heads of the major Federal agencies as an advisory group to them, and with a

small staff that would do a constant planning job of figuring out: "Where does the Federal Government stand today with respect to its hospitalization? What are the most urgent places where it ought to move?" And with respect not only to the needs of the Federal Government but with concern of the impact on the rest of the community.

Mr. BOLLING. How much authority should such a group have? Or would it gain its authority only through the President?

Dr. GINZBERG. I would think it should be only through the President. It is a planning agency.

Mr. HARDY. May I follow up on that for just a minute?

You said you thought they should not necessarily all be doctors, but you thought they ought all to be professional people. I do not know that I fully understand just what you mean by "all professional people."

Dr. GINZBERG. I withdrew that, as a matter of fact. I simply meant there ought to be one or two out of the people at least, and probably two, who had detailed experience in hospitalization and medical problems.

Now, I think you could have a successful businessman who has just generally good competence in dealing with complicated organizational problems, as a third member. But I think two people ought to have some really first-hand medical background and hospitalization experience.

Mr. HARDY. In view of the fact that a good many of the cases or a relatively high percentage of the cases are mental cases, I was just wondering what type of professional men might be most effective in giving consideration to the needs of those cases.

Dr. GINZBERG. I think there is a difference between the planning board and the amount of advisory help that they would try to get, because I would think that such a planning board should never have all the background that it needed. But one of its real ways of operating would be to get help from additional specialists, with respect to certain problems.

Mr. HOFFMAN. Following that line of thought, and with respect to the last paragraph on page 11, you say, with respect to this agency:

> Such a top level agency, if it were to discharge its responsibilities properly, would have to concern itself not only with the Federal medical services, but also with the impact of the actions of the Federal Government on the civilian sector.

Now, you did not want too many Government people in this board or agency. Is that right?

Dr. GINZBERG. That is right.

Mr. HOFFMAN. Well, did not the Hoover Commission, or those who created the Hoover Commission, have that same idea? Because I noticed on page 5, in the last paragraph, you say:

> The membership of the task force should be noted. It was composed primarily of doctors distinguished for their attainments in their respective specialties, including medicine, surgery, psychiatry, public health, research, and hospital administration. It also included four laymen, one of whom, Mr. Tracy Voorhees, served as chairman.

You go on to say:

> What is surprising about the membership is the fact that, with the exception of Dr. Paul Hawley, there was no one on the task force who had an intimate knowledge of the history and operations of the Federal Medical Services.

Now, Dr. Hawley did have the experience?

Dr. GINZBERG. Oh, yes.

Mr. HOFFMAN. And these others met your requirements as to membership and qualification for membership on the board, did they not?

Dr. GINZBERG. I think there is a real distinction to be made when it comes to this task force, which was set up to recommend detailed changes in the Federal medical services. And I felt if you were going to make detailed recommendations about a group of Government agencies, you really ought to have had quite a lot of detailed knowledge about how those agencies operate, what their missions are.

Mr. HOFFMAN. And Dr. Hawley had that, did he not?

Dr. GINZBERG. Yes.

Mr. HOFFMAN. And you disagreed with him pretty quickly.

Dr. GINZBERG. No, that is your conclusion; very slowly.

Mr. HOFFMAN. The task force had the same kind of organization that you recommend set up?

Dr. GINZBERG. No.

The CHAIRMAN. Doctor, most of these veterans' organizations have been against this bill because they believed that the type of medicine, the type of care, necessary to disabled veterans is so different from the medical problems raised in the Army, the Navy, and Air Force. What is your thinking on that?

Dr. GINZBERG. Well, I think we have real knowledge about that. That is, if it is true—and I still stand by these figures—that just under 70 percent of all veteran patients are patients suffering from mental disease and tuberculosis, we know that that is an infinitesimal percentage of the Army and Navy patients. We do have a substantially different kind of patient load. In the Army and the Navy you are dealing with specially screened personnel, able-bodied young men, and somewhat older officers on occasion, who come into a hospital for short-run treatment; except in war time, that is. And the veterans' problem is heavily weighted in terms of people who are suffering from these chronic illnesses, mental illness, tuberculosis, and then the paraplegics and other special groups.

The CHAIRMAN. And even in wartime one who was incapacitated by the rigors of war would be a veteran and would be taken over by the Veterans' Administration for further care?

Dr. GINZBERG. I think Dr. Hawley made quite a point of that in the task force report, but it was confused a little bit. He felt that in the last war we could have transferred from the Army and the Navy somewhat more quickly those patients who were definitely not going to return to military service. I think the fact that he was in Europe and did not know that the Veterans' Administration had no personnel to receive those patients is one omission. I was in the middle of that problem. In fact, the Army and the Navy had to supply personnel to the Veterans' Administration to make it possible for them to continue to operate, first having taken away a lot of their personnel by calling them to active duty. But I think that is a very special problem, which has been restudied recently by the Secretary of Defense, as to what the break point ought to be in wartime between transferring men who are so sick or injured that they really are no longer of military use, and therefore ought to go to the Veterans' Administration earlier. That is a special problem.

The CHAIRMAN. Do you feel that we could pass legislation which would anticipate and take care of the conditions raised by war?

Dr. GINZBERG. I would like to think that a top-level planning agency, if one had such an agency, should be able to do that.

The CHAIRMAN. I mean legislation such as this. Do you think that this type of legislation would contribute anything to making provisions to take care of the changes necessitated by war?

Dr. GINZBERG. Well, I feel, in accordance with Mr. Hoover's minority dissent, that this bill would weaken the medical departments of the armed services. That was Mr. Hoover's belief in his minority opinion, and I would agree with that.

So I think that the total impact of passing H. R. 5182 would be to put the military medical departments back behind an eight ball, even if you could work it out, which I question, on the basis of: How would you actually transfer some of these station hospitals?

The CHAIRMAN. I was interested in the question you raised there, about the ability of this body created here to operate on a military post, that the Army must be supreme in handling its affairs.

Dr. GINZBERG. I have tried to inform myself as to that, but I don't know of any military installation having such an outside organization operating on a military post as an integral part of the post.

Mr. HOFFMAN. You have repeatedly stated that Mr. Hoover opposed this plan.

Dr. GINZBERG. No, I said he had a minority opinion about this part.

Mr. HOFFMAN. Now, the truth of the matter is that what Mr. Hoover objected to was that the Board which would be here created did not have authority enough, is it not?

Dr. GINZBERG. That is correct.

Mr. HOFFMAN. That is to say, he wanted a stronger plan, with a board with more authority, did he not?

Dr. GINZBERG. But look where the authority remains. It remains with the agencies, according to Mr. Hoover.

Mr. HOFFMAN. And Mr. Hoover wanted it with the Board in this particular case.

Dr. GINZBERG. That is right.

Mr. HOFFMAN. And in other cases, he wanted centralization of authority through the head of the department.

Dr. GINZBERG. That is correct.

The CHAIRMAN. Any other questions?

You and the witness agreed that time.

Mr. HOFFMAN. He could not help it. It is right there in the report. Anybody, if he never went to high school, could read that.

The CHAIRMAN. We thank you very much for your contribution, Dr. Ginzberg.

It has been very, very fine, and we are happy to have had the benefit of it.

I would like to say to the members of the committee that we have with us Dr. Jones, who has brought into our midst a group of German legislators.

Doctor, would you like to present them to us at this time?

Dr. JONES (Dr. Ralph G. Jones, Political Science Department, University of Michigan). Thank you very much.

I would like to present Dr. Karl Kanka, of Offenbach, member of the Landtag, or Legislature, of Hesse; Dr. Friedrich W. Reuss, of

Wiesbaden, Deputy Minister of Economics and Transport for Hesse; and Dr. Hans Huber, of Heidelberg, judge of the county court and member of the Heidelberg City Council.

The CHAIRMAN. I would like to say to them that we are considering a bill to consolidate certain hospitals, and medical and public-health functions of the Government into a medical unit, and we are trying to determine whether it would be to the best advantage to take the hospitals from our Army, Navy, and Air Force, and other Federal hospitals, and consolidate them into one unit and operate them in that way.

We have been holding hearings on this matter for the past 2 weeks, and probably will continue from time to time for the next 2 or 3 weeks.

Dr. Ginzberg, who served in a civilian capacity during the last war with our Armed Forces, and who is an associate professor of economics in Columbia University, has been giving us the benefit of his experience and his ideas on this matter.

Would any of you doctors like to ask Dr. Ginzberg any questions about what he has testified?

We are certainly happy indeed to have you with us, and we are honored to have you with us.

I would like to say to the members of the committee that two resolutions of disapproval have been filed to two of the President's plans lately sent down. The numbers are 24 and 27. One has to do with the creation of a new Department of Health, Education, and Security, and the other has to do with the Reconstruction Finance Corporation.

Mr. BOLLING. By whom were they filed, Mr. Chairman? Do we have that?

The CHAIRMAN. Mr. Hoffman of our committee filed two of them.

It is necessary that we give attention to these matters right away; and so, having consulted with him, I am going to call a meeting for tomorrow morning to take up these plans and determine our position on them, and so notify the Congress.

I think it is better to take them up tomorrow morning, because many of us get away on the week ends, and we do not come back on Monday.

We would like to start this matter off, because we have got to file by Thursday at the latest. So that means we have got to draw up the reports, and so forth. I am going to ask you to be present on time tomorrow, and we will go into these matters and reach our findings on them.

Are there any other matters to be brought up by any member of the committee?

Mr. DONOHUE. Is that to be a hearing on those, Mr. Chairman?

The CHAIRMAN. Yes; the hearings on those will start tomorrow. I am going to ask you to be on time, please, so that we can get right to them. Are there any other questions?

If not, we stand adjourned until tomorrow morning.

(Whereupon, at 11:45 a. m., the committee adjourned to reconvene at the call of the Chair.)

UNITED MEDICAL ADMINISTRATION

THURSDAY, JUNE 22, 1950

House of Representatives,
Committee on Expenditures in the
Executive Departments,
Washington, D. C.

The committee met at 10 a. m., the Honorable William L. Dawson (chairman) presiding.

The Chairman. The committee will come to order.

We will resume hearings on H. R. 5182. H. R. 5182 is a bill to consolidate hospital, medical, and public-health functions of the Government into a United Medical Administration.

As I look around I see those here who have attended all of our meetings. I know they know the purpose of the bill, so we will dispense with reading it. We will proceed with the hearing of witnesses.

I am going to call Dr. Walter Clarke, executive director of the American Social Hygiene Association, New York, N. Y., as our first witness.

STATEMENT OF DR. CHARLES WALTER CLARKE, EXECUTIVE DIRECTOR, AMERICAN SOCIAL HYGIENE ASSOCIATION, NEW YORK, N. Y.

Dr. Clarke. Mr. Chairman and gentlemen, with your permission, I will read the statement which I believe has already been distributed to the members of the committee. This is a report of the action of the legislative committee and the executive committee of the American Social Hygiene Association. [Reading:]

The American Social Hygiene Association's committee on legislation met at the Harvard Club, New York City, at 6 p. m. on April 3, 1950. The subject for consideration was H. R. 5182, entitled "A bill to consolidate certain hospital, medical, and public-health functions of the Government in a United Medical Administration." The committee had before it copies of this bill and also the report of the Commission on Organization of the Executive Branch of the Government—medical activities, which H. R. 5182 closely follows. After full discussion the committee on legislation made a report to the American Social Hygiene Association's executive committee.

The report of the committee on legislation was presented to the executive committee of the American Social Hygiene Association on April 21 and was adopted with three amendments. These amendments have been made in the following statement:

GENERAL COMMENT

The association appreciates the objectives of the Commission on Organization of the Executive Branch of the Government and agrees that it is highly desirable to take such steps as are practicable to improve the efficiency and reduce the cost of medical and public-health services rendered by the United States Government

agencies. While we favor the provision of excellent and adequate facilities and services for the medical care and public-health activities which it is the duty of the Federal Government to provide, we consider it necessary to eliminate any waste, inefficiency, and duplication which may exist.

We note that the Commission itself was not in substantial agreement on their own report on this subject. Of the 12 members of the Commission one, Mr. Forrestal, dissociated himself from the entire report due to his position as Secretary of Defense. Mr. Hoover and Mr. Manasco demanded that the Advisory Board proposed in the bill should be a Board with powers to determine policy. The objections of Messrs. Acheson and Rowe were fundamental and opposed the setting up of a new agency, namely, the United Medical Administration. Messrs. Brown and McClellan objected to the inclusion of the hospitals of the Armed Forces in the proposed United Medical Administration. It is evident that the report and H. R. 5182 which implements it lack the support of the majority of the Commission. In fact only 4 of the 12 members accepted the entire report.

On the broad basis of national policy we, the executive committee of ASHA, question that it is desirable to separate medical services from the other interests and activities of and for special groups such as those in the Armed Forces and those served by the Veterans' Administration. Medical services are most effective when they are closely integrated with the activities of and the welfare services to personnel to be served.

DISRUPTION OF ESTABLISHED SERVICES

Creation of the proposed United Medical Administration would cause the disruption of the present reasonably well functioning organizations for public health and medical care within the Federal Government.

The United States Public Health Service was taken out of the Treasury Department and put into the Federal Security Agency only a few years ago. It is now proposed to uproot it again and place it in a newly created United Medical Administration.

The Air Force has only recently accomplished its separation from the Army and created its own Air Force Medical Corps. It is now proposed to uproot a large part of its medical service and place them in the United Medical Administration. Similarly it is proposed to place Army and Navy hospital service in the UMA.

The Defense Department has already made considerable progress toward the unification of medical services of all the Armed Forces. It is now proposed to transfer a large part of these services to the United Medical Administration.

The Veterans' Administration has only recently been reorganized, and its medical services brought to a high level of efficiency. It is now proposed to uproot these medical services, separate them from the other interests of and services for veterans and place them in the United Medical Administration.

All of these changes are proposed at a time when the cold war may at any moment become hot. These dangers should not be discounted. The risk of its becoming hot is so great that we are spending billions of dollars on military and naval preparedness.

It is a common error to say "A patient is just a patient no matter where or who he is." This disregards nearly everything we have learned about psychosomatic medicine. The ill or injured serviceman and veteran needs to be studied and treated in relation to his service and other conditions.

It appears to us that H. R. 5182 would inevitably make medical care less accessible, interpose problems and costs of transportation and involve more and more red tape in securing medical care including the assignment of personnel and obtaining of medical supplies. It is not shown in any of the reports available to us how or to what degree efficiency and economy would be gained by the proposals embodied in H. R. 5182. On the contrary, we believe that medical care would be less available, less efficient, more involved in red tape and in the end probably more expensive.

THE ARMED FORCES

Specifically H. R. 5182 proposes to take away from the Armed Forces and assign to the United Medical Administration (1) all their general hospitals, (2) all their station hospitals, (3) all dispensaries of the Navy—with certain exceptions in each case.

The member of the task force whose opinion seems to have carried the greatest weight so far as the necessary medical service for the Armed Forces is concerned did not at any place in the record of the task force recommend that station

hospitals and Navy dispensaries be transferred to the United Medical Administration. He pointed out again and again that such services are essential to the practice of good military medicine.[1]

EFFECT ON PERSONNEL OF THE ARMED FORCES

The removal of the station hospitals and Navy dispensaries from Air Force, Army, and Navy posts and stations could be hazardous to the health and life of military and naval personnel. In peace time the majority of Navy accidents take place in the navy yards and the majority of Air Force accidents take place at the air fields. Delay even of an hour in obtaining immediate hospitalization may cost the life of an injured man. Furthermore, it would not be safe to delay even for 5 or 6 hours the transportation of many of the medical and surgical conditions which arise at posts and stations of the Armed Forces. We believe that better and more immediate medical care will be provided for service personnel and their dependents by keeping facilities and personnel close to the people to be served and integrated with their activities and other services for their welfare.

EFFECT ON PROFESSIONAL MEDICAL SERVICE

The military medical officer now has the professional advantage of giving all medical care to service personnel and to their dependents. Under the proposed conditions of H. R. 5182 military doctors to a large degree become merely admission and emergency-aid officers. They would be obliged to refer all serious medical and surgical cases to the UMA hospitals since the posts and stations of the Armed Forces would, with certain exceptions, have no hospitals or naval dispensaries.

This would provide a very unattractive kind of medical career for physicians considering service in the Armed Forces. Good medical experience depends on observation and study of patients from the first presentation through diagnosis and treatment to cure, and on research. Research varies from great and highly significant projects to humble studies which can be made by any doctor at any post hospital, but it provides the lifeblood of modern medical practice and sustains the morale of the medical men in any service. Removal of the station hospitals and of Navy dispensaries would make good medical experience impossible to the great majority of military and naval medical personnel.

It is hardly feasible at one center for each branch of the Armed Forces to train sufficient men in hospital administrative duties so that there would be an adequate reserve group of hospital administrators to direct military hospitals when and where needed. By rotation some officers could be given training but between training periods, having no hospitals to direct, they would become rusty and out of date regarding latest and most effective administrative methods. This appears to be a serious matter in view of the possible need for a sudden vast expansion of military and naval medical services in an emergency which may involve millions of civilians as well as members of the Armed Forces.

It is believed that so far as the Armed Forces are concerned, the proposal presented in H. R. 5182, if carried out, would make a career of military and naval medicine so unattractive and professionally so unprofitable as seriously to interfere with recruitment of doctors. This would be very serious for the Armed Forces which are already short of medical personnel.

THE PUBLIC HEALTH SERVICE

We are especially alarmed at the proposals of H. R. 5182 with reference to the Public Health Service. The provisions of the bill abolish the Service as it has existed for many years, putting an end to the corps of commissioned Public Health Service officers.

No branch of the Federal Government has a more distinguished history and none has rendered a greater service to the Nation than the Public Health Service. It has well established traditions, excellent working relations with State health authorities and through them down to the smallest hamlet in the Nation. It has always been free from political influence. The esprit de corps of the officers has always been high because they have been proud of the Service and its uniform and of its magnificent history of scientific accomplishment. H. R. 5182 proposes to sweep all this away and substitute a civil service status for the present and historic position of Public Health Service commissioned officer which is equal

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[1] See report of the task force on this subject, especially p. 30.

in all respects to that of medical officers of the Army, the Navy, and the Air Force. The proposed Public Health Service under the United Medical Administration will offer less attractive careers to able young physicians, recruitment will be less productive, and the quality of service will suffer as a result.

One has only to review the history of the Public Health Service in the recent war, World War II, to appreciate the great advantage of a semimilitary uniformed corp of commissioned Public Health Service officers. Throughout the war Public Health Service officers served with the Armed Forces in positions of strategic importance both in the United States and abroad and to the great advantage of military and civilian health conservation.

Furthermore, H. R. 5182 removes the Public Health Service from the Federal Security Agency, its natural setting closely related to other social, scientific and educational agencies, and places it in a huge organization whose budget, personnel, and major interests will be devoted to curative medicine and the administration of hospitals. Past experience indicates that this is not the best setting for broad constructive public health work. It will be noted that in most large cities and States, public health departments are separate from and independent of hospital departments. This precedent should be followed by the Federal Government.

Until such time as the public-health functions of the Federal Government are given higher status and greater influence and prestige in a Department of Health or of Health, Education, and Security, with representation in the President's Cabinet, we believe that the Public Health Service should be permitted to remain in its present status and relations in the Federal Security Agency.

NEED FOR FURTHER STUDIES AND EXPERIMENTS

We suggest that economies could be brought about and waste, if any, eliminated by appropriate action at the level of the Bureau of the Budget through the control of appropriations and without embarking on hazardous experiments affecting the care of the sick and incapacitated servicemen and veterans.

We believe that the process of unification which has made considerable progress within the Department of Defense will produce substantial economies without disruption of services.

The task force on medical services says on page 9 of their report, "Our study is in a real sense only a beginning." We are convinced that basic studies should be continued in the expectation that acceptable solutions will be found for the medical and health problems confronting the Federal Government. Rather than undertake to carry out on a national scale the program proposed in H. R. 5182, characterized by the task force itself as "revolutionary," it would be wise to adhere to policies shown by local, State, and national experience to be sound and safe. Departures from such policies should only be undertaken on a limited scale in the form of "pilot" demonstrations and experiments. Such pilot demonstrations and experiments should, however, be encouraged in the spirit of administrative research.

The CHAIRMAN. Mr. Hoffman.

Mr. HOFFMAN. Do you contend that the Hoover Commission did not support this method of legislation?

Dr. CLARKE. Yes. I gather from the report which I saw describing the medical services there were more members who did not accept the whole report than there were who did accept it.

Mr. HOFFMAN. They finally sent up a report endorsing it; did they not?

Dr. CLARKE. Yes; they sent up a report.

Mr. HOFFMAN. There are 25 of us on the committee, and each one of us may find some fault with a particular bill, but we finally send it out with a favorable report. That is about what the Commission did?

Dr. CLARKE. Yes. They sent up a report, but in the report itself the members of the committee stated their objections to the report.

Mr. HOFFMAN. They also said, in effect, it was the best they could do; did they not?

Dr. CLARKE. I do not know that they did that.

Mr. HOFFMAN. Mr. Hoover and Mr. Manasco thought the board should have more power.

Dr. CLARKE. Yes; that is right.

Mr. HOFFMAN. And some others had other ideas on different phases of it.

Dr. CLARKE. That is right.

Mr. HOFFMAN. But when they finally got all through they sent up a favorable report.

Dr. CLARKE. With their own reservations clearly stated in each instance.

Mr. HOFFMAN. Do you believe in unification or not?

Dr. CLARKE. Unification of what, sir?

Mr. HOFFMAN. Of govermental services, insofar as we can unify them?

Dr. CLARKE. I am not sure that I do in a broad sweeping sense. I would have to know what you were going to unify and how you proposed to unify them.

Mr. HOFFMAN. As you were speaking, I thought I heard you say that some service had already been taken out of——

Dr. CLARKE. Perhaps you mean my reference to the Department of Defense. From my contact with the medical officers there I know that considerable progress has been made in tightening up all around in the medical services within the Department.

Mr. HOFFMAN. You mean in an effort to consolidate or unify those services?

Dr. CLARKE. In keeping with the general over-all policy of the Department. After all, the Federal policy is unification there to the extent possible.

Mr. HOFFMAN. I gather that you are rather enthusiastic about this particular service because at the top of page 6 you say:

> No branch of the Federal Government has a more distinguished history—

and we will assume that is true.

Dr. CLARKE. That is the Public Health Service.

Mr. HOFFMAN. And listen to this:

> And none has rendered a greater service to the Nation than the Public Health Service.

Dr. CLARKE. Yes.

Mr. HOFFMAN. No branch of the Federal Government has rendered such a service?

Dr. CLARKE. I think that is true, being a public-health man.

Mr. HOFFMAN. The Government being sprawled out and spread out the way it is, how in the world can you make such a broad statement as that.

Dr. CLARKE. Well, if you would like to permit me plenty of time——

Mr. HOFFMAN. I think we cannot do that. I assume that we would have a long argument.

Dr. CLARKE. I am perfectly willing to be accused of a little prejudice there, as a medical man.

Mr. HOFFMAN. We will let it rest at that, because I really do not know. We should keep that little prejudice and enthusiasm—perhaps enthusiasm is better than prejudice—in mind when we evaluate your testimony.

Dr. CLARKE. Yes. I would be quite prepared to admit that, sir.

Mr. HOFFMAN. That is all.

The CHAIRMAN. Mr. Rich.

Mr. RICH. Dr. Clarke, I note on the first page of your general statement you make this comment:

> While we favor the provision of excellent and adequate facilities and services for the medical care and public-health activities which it is the duty of the Federal Government to provide, we consider it necessary to eliminate any waste, inefficiency, and duplication which may exist.

How far can you go in that statement?

Mr. HOFFMAN. May the record show one thing? There are four Republicans here earning their money and just one Democrat.

Mr. KARSTEN. One Democrat can handle it.

Mr. RICH. What do you mean by that—that it is the duty of the Government to provide medical care? How far would you go in that?

Dr. CLARKE. What we intended to say here is—the services and the care which it is the present legal obligation and duty of the Federal Government to provide.

Mr. RICH. You are talking about it right now, but in the next day, or the next week, how far are you going to go? How far do you want to go?

Dr. CLARKE. In the provision of medical care?

Mr. RICH. Yes. I am trying to find out whether you are one of these advocates of socialized medicine.

Dr. CLARKE. I suspected that, Congressman.

I should say, speaking for myself, I am not in favor of socialized medicine as defined by anyone. I lived a considerable time abroad and I have seen how it works, and my own personal opinion is I am not in favor of the proposals that have been put forward.

However, I should make this statement, that the American Social Hygiene Association has taken no position on that subject.

Mr. RICH. Do you mean the medical profession?

Dr. CLARKE. The American Social Hygiene Association, which I represent here, because, gentlemen, I am sure you would not be interested in my personal opinion.

Mr. RICH. Certainly I am interested in your personal opinion. You are the witness.

Dr. CLARKE. Yes.

Mr. RICH. If we have any people that are recommending socialized medicine here, as far as I am concerned, I just want to blot out everything they say because I am not interested in it. I think it is wrong, and I am interested in knowing what you think about it.

Dr. CLARKE. Are you thinking about universal compulsory health-insurance proposals?

Mr. RICH. No. I am thinking about the Federal Government looking after the welfare and health of everybody in this country and telling them what doctor they should have and whom they should go to to get medical care; where everyone would go to some office and secure medical attention they want at public expense.

Mr. HOFFMAN. Not that they want.

Mr. RICH. I do not want it myself, and I do not want anyone to tell me that I have to go to a certain doctor or medical center.

Dr. CLARKE. As a physician, I am as much opposed to that as you can possibly be.

Mr. Rich. That is the answer that I want. You speak my language exactly. I am interested in those people who are interested in that.

How far would you go, Doctor, in the recommendations of consolidating the departments of Government that deal, first, with health? According to the report given out by the Comptroller, Lindsay Warren, there are 28 departments of health and education. Now, if you get a consolidation of those 28 departments of health and education, will we be doing that by putting through this bill, H. R. 5182?

Dr. Clarke. Mr. Chairman, I feel reasonably sure, without being an authority on the subject, there is an opportunity for closer coordination and improvement of the services in the many agencies that are rendering medical and public-health services already under statute in the Federal Government. My own personal view of that is that the best way to do that is to bring them together under a Ministry of Health—a Department of Health.

I personally am strongly in favor of the establishment of a Department of Health in the Federal Government with Cabinet status.

Having lived abroad and seen how important the Ministries of Health are in European countries, the aid they are able to give, I just feel sorry we here in this country do not have it.

Mr. Hoffman. Will the reporter please read that answer? [The answer was read.]

Mr. Rich. Then the statement that he made awhile ago that he was opposed to socialized medicine as much as I am and the statement that he just made do not go together.

Mr. Hoffman. You do not have any of this independence abroad. However, I have never been over there.

Dr. Clarke. There is a distinction, I feel sure. That is one thing that ought to be very clearly understood, and you gentlemen probably do understand it and have had it explained much more at length than I can explain it here.

Mr. Hoffman. You would be surprised at what some of us do not know.

Dr. Clarke. The provision of medical care is not public health. It is something else that is quite different, and it is approached from an entirely different point of view. The giving of individual care to an individual patient in a doctor's office, or clinic, is not public health. It sometimes contributes to public health.

Mr. Hoffman. Do you mean that the people abroad are more healthy than we?

Dr. Clarke. No.

Mr. Hoffman. What do you mean? Find out what he means, Mr. Rich.

Mr. Rich. I am trying to.

Dr. Clarke. I believe that public health is so important and is so basic in the functioning of the Government that just as a city has a department of health, just as a State has a department of health, so the United States at the Federal level should have a Department of Health. There is just the same reason for it.

I do not know what States all of you gentlemen come from, but just as the State of Illinois has its State health department, which does not practice socialized medicine—it practices preventive medicine—from the same point of view, without becoming confused with socialized medicine, so-called, we need to have in this country a Na-

tional Department of Health with a competent public-health man sitting at the top and bringing in the public-health point of view to the consideration of the Cabinet on all social and industrial problems.

Mr. RICH. You speak about the State of Illinois. We will take Pennsylvania as an example.

Dr. CLARKE. You have an excellent department of health there.

Mr. RICH. We send doctors out to inspect our school children in every phase of the health program. In our industries we have people who check on the people who are employed.

Dr. CLARKE. That is right.

Mr. RICH. Now, you want the Federal Government to go out and do the same thing?

Dr. CLARKE. No.

Mr. RICH. Why not leave this alone in the States where they are doing it so well? I presume the same thing applies to the majority of the States.

Dr. CLARKE. Yes; it does. You are quite right.

Mr. RICH. If that is the case, why do we want to centralize this all here in Washington? We are centralizing everything here. I am trying to get away from it.

Dr. CLARKE. I agree. I do not want further centralization of authority. In a word, I think the easiest way to make clear what I am trying to see happen in my own country here is to keep the Public Health Service raised to the same position of influence and dignity that the parallel services abroad—in almost every country abroad——

Mr. RICH. Let us not get abroad again. I want to stay here. I am for America first, last, and all the time. You are talking about what is happening abroad. Are you an Englishman?

Dr. CLARKE. I am an American descended from Plymouth Rock Pilgrims.

Mr. RICH. I am a descendant from the English-Germans. I do not want any program that England has in medicine.

Dr. CLARKE. Congressman, they had an excellent public-health program separate and distinct from their medical care. I wish that I could get you to understand there is a difference between a medical-care program and a public-health program. That is one of the great risks of letting this thing go into the United Medical Administration. It is so hard to make people see, unless you have a lot of time; there is a real difference between the provision of hospital service, medical care and public health and preventive medicine. They are quite different.

Mr. RICH. Do all the doctors in this country make the distinction that you do?

Dr. CLARKE. I do not think so. I am sorry to say they do not.

Mr. RICH. Are you in a majority or minority?

Dr. CLARKE. I could make a guess and say that probably the majority of the doctors do now, especially the younger men who are coming up through the more modern training where there is more emphasis on preventive medicine.

Mr. HUBER. The majority are not necessarily right, are they?

Mr. RICH. The majority here now are just as wrong as they can be. My chairman, I think, is one of the finest fellows that I ever met, and I get along fine personally with these other fellows on the other side of the table and I love them all. I just cannot agree with them; that

is all. I just do not agree with you, Doctor, in some of the statements that you made. I do agree with you when you say that you are against socialized medicine, but when you want everything brought into the Government here in Washington, when we can do the same thing in the States, then I disagree. I think that we ought to stay back in the States and let the States handle that.

Dr. CLARKE. Did I say that? If I did, I want to withdraw what I said.

Mr. RICH. I was under the impression that you wanted the Federal Government to do it all.

Dr. CLARKE. Would you like for the reporter to read my statement?

Mr. RICH. I will quit right now, Mr. Chairman. I am glad that the witness has been before us.

Mr. KARSTEN. I was interested in your discussion about Great Britain. You say they have two programs over there, a public-health program and a medical-care program?

Dr. CLARKE. Yes.

Mr. KARSTEN. Are you familiar enough with that to be able to say whether or not the same administrator administers both programs, or do they have a separate administrator over there?

Dr. CLARKE. As I understand it—and I must say that it has been some years since I have studied it—the Ministry of Health, which is like our Public Health Service, has Cabinet status.

Mr. KARSTEN. That goes way back?

Dr. CLARKE. For many, many years. It has a supervisory relationship to this great, cumbersome plan of medical care and hospital care. You are getting me a little out of my field of special knowledge, but my understanding is that it is set up now as a separate administration.

Mr. KARSTEN. Would you call it a united medical administration over there—the arrangement that they have—or how would you term it?

Dr. CLARKE. It is not like the proposal in this bill. The British armed forces are not included.

Mr. KARSTEN. All the rest are conglomerated together into one thing?

Dr. CLARKE. I am not too sure just how much authority the Ministry of Health has over the medical-care program. I am afraid that I am a little vague on that, sir.

Mr. KARSTEN. That is all I have, Mr. Chairman.

The CHAIRMAN. Mr. Riehlman.

Mr. RIEHLMAN. I have no questions.

Mr. HUBER. Would the adoption of this plan provide more doctors?

Dr. CLARKE. In my opinion, and in the opinion of my committee, this would militate strongly against the getting of doctors. As I said in my statement, it makes a career, a career in the Armed Forces or the Public Health Service, substantially less attractive than it was before. That, I think, is particularly true with the Armed Forces, where they practice not only preventive medicine but curative medicine. I think that it would make the filling up of the ranks of the Medical Corps of the Army, Navy, and Air Force substantially more difficult. I do not believe that it would aid at all in obtaining more physicians generally. Of course, there is the problem to what extent we need more physicians.

Mr. HUBER. If we have the same number of doctors today that we had in 1900, we need more, do we not?

Dr. CLARKE. I would think so. In fact, it seems to me quite certain in certain fields of medicine there is a drastic need for more men. There is in public health. There is a need for men in military medicine. There is a great need for more psychiatrists and more pathologists. Whether there is a need for more general physicians, or whether there is a need only for a different distribution of those doctors, I am not quite sure. There is a different point of view about that among authorities who have gone into the subject in great detail.

Mr. DONOHUE. Being as close to the situation as you are, Doctor, what are the American Medical Association and these other associations doing to increase the number of doctors in this country?

Dr. CLARKE. Well, most of us—and I believe the American Medical Association is also aiding—are promoting the present congressional bill to give financial aid for medical education. I happen to be, among my other capacities, a clinical professor at the Harvard School of Public Health. I teach there a part of the year. I can testify that there is need for aid to medical schools and to schools of public health, and it is a substantial need.

Mr. DONOHUE. Do you think that schools like Harvard, Yale, Michigan, need aid from the Federal Government in order to expand?

Dr. CLARKE. Yes, they do.

Mr. DONOHUE. Do you know how much of a surplus, by way of endowments, Harvard has at the present time, and Yale?

Dr. CLARKE. Available for the medical schools and the schools of public health? No, I do not know.

Mr. DONOHUE. In the general endowment fund.

Dr. CLARKE. We are endeavoring desperately to raise more from that endowment fund right now.

Mr. DONOHUE. That is good policy.

Mr. HARVEY. Would my colleague yield at this point? I am interested along that line that you have just been pursuing—the need for Federal aid to medical education. Why should Michigan, for example, have need for Federal money for medical education, or Indiana, my own State?

Dr. CLARKE. Do you mean why should any medical school need aid that the State itself cannot provide?

Mr. HARVEY. That is right.

Dr. CLARKE. In other words, if Michigan needs some more money, why does not the State provide it?

Mr. HARVEY. Yes. What money does Uncle Sam have that Michigan does not have?

Dr. CLARKE. I am not sure that they have any except the difficulty exists, of course, in getting the appropriations from the State legislatures. The cost of medical education is so great. Of course, the student pays only a small fraction of the amount.

Mr. HARVEY. That is right.

Dr. CLARKE. There are many men coming, for example, to Michigan University's medical school—and I happen to know the school right well—from other States. Perhaps half of the student body in the medical school at the University of Michigan would be from outside the State of Michigan. Now, possibly the State legislature of Michigan would have a little difficulty in being convinced they should pay

for that medical education, and yet it is of advantage to the whole country.

Mr. HARVEY. From the statistics would you say that Michigan was one of the poorer States?

Dr. CLARKE. Oh, I would not say so; no. I would say that Michigan is one of the richer States.

Mr. RICH. Will my colleague from Indiana let me ask a question right here?

Many people think it is easier to get money out of the Federal Government than it is out of the States, and yet the States have more money than we have in the Federal Government.

Mr. HARVEY. I was just going to come to that point. I have had experience, I might say, in Indiana in this particular field. Out there I was on a committee that was responsible for the financing of our school of medicine in Indiana.

Dr. CLARKE. I know that school, also.

Mr. HARVEY. I do know that we made a study of many other States substantiating our actions in Indiana, and I am of the impression, contrary to what you think, I believe, that the States themselves can be made, and will be fully responsive, to their individual responsibilities in this particular matter, and that your "quickie" way, as I think you will admit, in the long run will not actually solve the problems, because it will have a tendency to further weaken the feeling of responsibility of the various States for their medical schools.

Dr. CLARKE. Mr. Chairman, I am afraid that I have been lured out of my own special field of competence with these attractive statements that have been made by these gentlemen. They have been dragging bait before me, and I should not be expected to make any kind of serious statement without having studied the subject more fully.

Mr. HARVEY. I would just like to conclude by saying that I believe, Doctor, the States themselves are—and I think that you will agree with me—becoming aware of the need. They do know that medical education is not a cheap thing.

Dr. CLARKE. That is right.

Mr. HARVEY. And they will, if given time, solve the problem, and if they are permitted to solve it at the State level it will be solved to the ultimate good not only of the people but the medical profession as well in a much better fashion.

Dr. CLARKE. I would say to the extent that it can be solved that way, that will be splendid. That is better than by Federal appropriation.

Mr. HUBER. Am I to believe, then, that most of the medical students turned out are to some extent responsible to the States for their education?

Mr. HARVEY. I would not say that a student of a given medical school, say of Ohio, your State, or Indiana—If I interpret your question correctly—would be held any more responsible than a graduate of Ohio State in the field of engineering or agriculture.

The CHAIRMAN. Are there any other questions?

Mr. DONOHUE. I would just like to get this clear in my mind because of a question that Mr. Huber asked. Do I understand that there are the same number of graduates coming out of medical schools now as came out of medical schools back in 1900?

Dr. CLARKE. That there is the same number that came out in 1900?

Mr. DONOHUE. Yes.

Dr. CLARKE. I think that you are forcing me to extemporize here, but I believe that in 1900 there were many more medical schools, and there were so many so-called diploma mills which were issuing certificates and enabling a man to practice medicine without his having had an adequate education. Somewhere along between 1900 and 1922 and 1923, a clean-up was made of these diploma mills, so there are actually just a fraction as many medical schools now, and probably a fraction of as many graduates.

However, in every State now the standards have been set by the State. Almost all the medical schools are class A schools. There are one or two that are not. The standards of medical education are excellent. They are as good in this country as anywhere in the world, probably at the moment better, so we may have actually fewer men coming out. We certainly have fewer medical schools than at the beginning of the century.

There has, however, been an increase in the output of all medical schools, I think. Beginning during the war we upped the enrollmentby 10 percent in most schools, so there are more coming out now than there were, say in 1938–39.

Mr. DONOHUE. What arrangements were made in these different schools to up the enrollment 10 percent?

Dr. CLARKE. Do you mean how did they manage to do it?

Mr. DONOHUE. Yes.

Dr. CLARKE. By stretching their facilities. The facilities that would be a problem in such a situation would be primarily the laboratory facilities, because you can put so many chairs in a lecture room, you can have a few more students going around to a hospital visiting the sick and getting instructions, but you cannot extemporize the laboratory facilities for anatomy and physiology and biochemistry and all the rest. What they had to do was just to crowd in another tenth more people. As soon as you go beyond that tenth, I am advised by my friends who are deans in medical schools—without providing funds with which to increase the facilities—and that means a staff as well—you would immediately run the risk of inferior medical education. You cannot crowd them in without providing adequate faculty and adequate facilities.

Mr. DONOHUE. Is anything being done at the present time, to your knowledge, to expand the facilities with which to enable medical schools to turn out more students?

Dr. CLARKE. I am not able to give you a specific example of that. I do not believe at Harvard there is any building going on at the moment to increase our limited facilities. We have greatly increased the School of Public Health. We have doubled the enrollment.

Mr. HUBER. Why is that, sir?

Dr. CLARKE. In the school of public health, which takes medical men that are already graduates of medicine and the instruction is then on the basis of graduate instruction, you do not have to have the same kind of facilities that you do in a medical school. What we did there was to buy an additional building and that just about doubled our capacity for teaching. We equipped new laboratories.

Mr. HOFFMAN. Am I correct in understanding you to say that the public health service abroad, as distinguished from socialized medicine, was better than ours?

Dr. CLARKE. Oh, no. I do not think that there is any public health service——

Mr. HOFFMAN. That is all I want to know.

Dr. CLARKE. I did not say that for a moment.

The CHAIRMAN. I was interested in two statements that you made. On page 2, the second paragraph, you said:

> Medical services are most effective when they are closely integrated with the activities of and the welfare services to personnel to be served.

Dr. CLARKE. Yes.

The CHAIRMAN. Would not that account for the distribution of some of our medical facilities?

Dr. CLARKE. It does.

The CHAIRMAN. In our Government?

Dr. CLARKE. That is right.

The CHAIRMAN. The mere fact that they are not all in one department does not mean that they should not be placed where they are placed?

Dr. CLARKE. That is right.

The CHAIRMAN. On the top of page 6 of your statement you say:

> No branch of the Federal Government has a more distinguished history and none has rendered a greater service to the Nation than the Public Health Service.

That is the Public Health Service that is now a part of the Federal Security Agency?

Dr. CLARKE. That is correct.

The CHAIRMAN. Are you speaking of the service that they rendered during the last war?

Dr. CLARKE. I am thinking of their whole service—their magnificent research, for example, on pellagra, that was carried on before the First World War, and their magnificent research in penicillin and their basic studies in epidemiology of every communicable disease, and all that goes back to just about the time when the Service got its first appropriation. They first got an appropriation in 1915; that is, to the Public Health Service as such.

The CHAIRMAN. In the administration that contains Public Health we have Child Welfare and Aid to Dependent Persons where medical services are indicated?

Dr. CLARKE. That is right.

The CHAIRMAN. The health feature is just a subsidiary feature of the main purposes of these Bureaus, and under that heading would come the medical services that are integrated with the main activities?

Dr. CLARKE. That is right.

The CHAIRMAN. You recommended departmental status for the Social Security Administration as it now exists. That has been recommended to the Congress, I think, by every President since 1920, and on the top of page 7 of your statement you say:

"Until such time as the Federal health functions of the Federal Government are given higher status and greater influence and prestige in a Department of Health, or of Health, Education and Security.

with representation in the President's Cabinet, we believe that the Public Health Service should be permitted to remain in its present status and relations in the Federal Security Agency."

You would be in favor of such a status established now, would you not?

Dr. CLARKE. I would be very definitely in favor of the Department of Health, and I am prepared to take Health, Education and Security as the second best.

The CHAIRMAN. If it were not possible to get the Department of Health now, you would not object to the establishment of a Department of Health, Education and Security?

Dr. CLARKE. I would not.

The CHAIRMAN. I am interested in that, Doctor, because I know that you have made a special study of public health. We have had doctors so testify, and I think it is the position of the American Medical Association, that they wanted a Department of Health and they object to the establishment of a Department of Health, Education and Security because they cannot get the other now. You would not take a stand like that, would you? I will withdraw the question because it is unfair to you.

Dr. CLARKE. I do not mind answering the question. Again I say that the American Social Hygiene Association, as such, has not taken a stand. I personally prefer the Department of Health as the American Medical Association does, but I am a little more inclined to yield to the second best, which I think is the Department of Health, Education and Security.

The CHAIRMAN. You would not take the position of a dog in the manger where there was some hay, and because you could not eat hay you would keep the other animals from eating the hay?

Mr. HUBER. I am opposed to socialized medicine, but you cite the remarkable achievements of the Department of Public Health. Is that not State medicine?

Dr. CLARKE. Oh, no.

Mr. HUBER. Where is their incentive?

Dr. CLARKE. The great achievements of the Public Health Service that have been most conspicuous are some very important research and discoveries. Actually, the most important, from the standpoint of human welfare, is the setting of standards, the creation of excellent practices in public health, and inducing, persuading the States to adopt those methods in developing sound public health administration and selling the idea to the State and local authorities.

I suppose every member of the committee understands that the Public Health Service has no authority at all over a State health department. They have no authority at all, and I do not think they seek any authority. They have achieved their great results by the soundness of their program, and by the high quality of their personnel. That is the way they have gotten their results.

The CHAIRMAN. Thank you very much, Doctor. You have made a great contribution to our deliberations.

Dr. CLARKE. Thank you, sir.

The CHAIRMAN. At this time we will hear from Mr. Earl B. Steele, a member of the staff of the Chamber of Commerce of the United States. Mr. Steele.

STATEMENT OF EARL B. STEELE, MEMBER OF THE STAFF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES

Mr. STEELE. Mr. Chairman and gentlemen, my name is Earl B. Steele. I am a member of the staff of the Chamber of Commerce of the United States. Our witness today was to have been Mr. Frank P. Leslie, and he has asked me to come and apologize for his inability to be here. His brother was stricken with polio in New York and he is at his bedside. He also asked me to request that you place his statement in the record, and asked me to express his appreciation for the opportunity afforded him to be heard.

The CHAIRMAN. We regret very much that he could not be with us today, because this meeting was set mainly with the view in mind of taking his testimony, since he could not be here until this morning.

Mr. STEELE. He appreciates that.

The CHAIRMAN. It is with deep regret that we learn of the illness of some member of his family dear to him, and I wish that you would express to him the sympathy of this committee.

Mr. STEELE. I will, sir.

The CHAIRMAN. Please tell him that we will file his statement.

Mr. STEELE. Thank you, sir.

The CHAIRMAN. Do any of the gentlemen present wish to ask Mr. Steele any questions? He has filed a statement setting forth the views of the Chamber of Commerce, which will be in the record.

Mr. RICH. The one question I would like to ask is whether the chamber of commerce votes yes or no on H. R. 5182.

The CHAIRMAN. I have not read the statement, but whether it is pro or con, it will be filed in the record here.

Mr. RICH. If we file that statement, many of us will not read and digest all of the information that is contained therein.

Mr. HARVEY. You will find it, Mr. Rich, in the third paragraph on the first page.

Mr. STEELE. Yes. We favor the principles of it, sir.

The CHAIRMAN. They are for it, sir. Thank you very much, sir.

(The statement of Frank P. Leslie is as follows:)

STATEMENT OF FRANK P. LESLIE, PRESIDENT, THE JOHN LESLIE PAPER CO., MINNEAPOLIS, MINN., AND MEMBER OF THE ADVISORY COMMITTEE ON GOVERNMENTAL AFFAIRS OF THE CHAMBER OF COMMERCE OF THE UNITED STATES

I am Frank P. Leslie, president of the John Leslie Paper Co., of Minneapolis, Minn., and member of the advisory committee on governmental affairs of the Chamber of Commerce of the United States.

The chamber is a federation of more than 3,000 chambers of commerce and trade associations with an underlying membership of 1,300,000 businessmen.

I am appearing in behalf of that organization in support of the principles of H. R. 5182, to create a United Medical Administration.

The chamber's policy is determined by a vote of its members. At our last annual meeting, in May of this year, with more than 2,000 delegates in attendance from all parts of the United States, our policy calling for active support of the recommendations of the Commission on Organization of the Executive Branch of the Government was reaffirmed. One clause of that resolution reads as follows: "Of particular interest at this time is legislation which would consolidate the Federal medical services." The text of the resolution will be found in an appendix to my statement.

It was my privilege to work for the Commission on Organization as assistant to Secretary James V. Forrestal, who was one of the 12 members. My observations while serving with the Commission convinced me of the urgent need for a

unification of Federal medical services, and this opinion has been confirmed by the policies adopted after serious deliberation by the Chamber of Commerce of the United States. I therefore submit that a properly managed United Medical Administration would—

(1) reduce the cost of hospital construction by hundreds of millions of dollars;

(2) make available a pooled hospital system which could quickly be adopted to civil defense needs in time of national emergency;

(3) improve the Nation's services to veterans;

(4) deprive veterans of none of their present benefits or services;

(5) raise the standard of medical care for members of the Armed Forces;

(6) conserve scarce medical talent;

(7) permit more attention to be given to the chronic diseases which fill most of our Federal hospital beds;

(8) provide a better opportunity to integrate Federal hospitals with the non-Federal hospital system;

(9) provide an agency to coordinate and stimulate Federal medical research and public health activities;

(10) provide a single, standardized supply system for all Federal medical items.

And now, Mr. Chairman, I would like to speak in more detail on each of those 10 considerations. First, on the subject of savings:

1. SAVINGS

The estimate that hundreds of millions of dollars in construction costs could be saved by a United Medical Administration is based on several considerations.

The agencies affected by this bill—Veterans' Administration, Army, Navy, Air Force, and Public Health Service—are now planning, building, and operating hospitals across the country, each for its own clientele, apparently without considering the facilities available in, or the needs of the others. For lack of any central plan, there are vast duplications of Federal medical services, the total cost of which amounts to approximately $2,000,000,000 a year.

The task force on Federal medical services of the Commission on Organization, which was comprised of 16 members, 11 of them doctors, and which was presided over by Col. Tracy M. Voorhees, reported the following situation as of June 30, 1948:

All Federal hospitals, with a capacity of 255,000 beds, had 155,000 patients—an occupancy rate of 61 percent.

There has been some criticism of those figures, largely based on the fact that they related to hospital occupancy rate on a single day, in the summer, when illness was at a minimum. Recently, however, a thorough study of the Federal hospital occupancy rate has been made by the Subcommittee on Investigations of the Senate Committee on Expenditures in the Executive Departments. This subcommittee submitted an interim report on May 23, 1950, showing that in 1948, Federal hospitals as a whole had an average daily occupancy rate of 63 percent of constructed bed capacity, and that in 1949, the average daily occupany rate was 69 percent of constructed bed capacity. There was a very slight increase in the average daily patient load in 1949, but the closing of a large number of military hospital facilities brought an increase in the average daily occupancy rate of all Federal hospitals.

The interim report of the Senate subcommittee also disclosed that the various Federal agencies have 85 additional hospital facilities either under construction or authorized for construction, at a total cost of approximately $1,000,000,000. Of these 85 new facilities, 79 are for the Veterans' Administration.

Also, the interim report showed that veterans' hospitals had a constructed capacity of 107,062 beds in 1949, and the Chief Medical Director of the Veterans' Administration has said that not in the foreseeable future can his agency expect to have enough medical talent to staff more than 120,000 beds. Yet the VA building program calls for almost 40,000 more beds which, added to the 107,062 already available, would be 27,000 more beds than could be staffed.

The points I would like for this committee to consider are these: In the first place, even though the bed-count figures submitted by the task force of the Commission on Organization might be open to question, there is a large unused bed capacity in the Federal hospital system as a whole, and a billion-dollar program of additional construction is under way. And in the second place, beds are being built which cannot be used in the foreseeable future.

The task force made spot checks in several areas, covering one-sixth of the Federal hospital system. In these areas alone it estimated that more than

$100,000,000 in construction costs could have been saved by a unified medical system. If one assumes this to have been a typical sampling, there arises the prospect that $600,000,000 could have been saved just in construction costs.

I also call the committee's attention to the following statement by the task force:

"The future program also includes badly located hospitals, products not of design but of pressures. To place these hospitals where they will have difficult staffing problems, and will lack the intimate day-to-day advice of expert part-time consultants from the Nation's best teaching hospitals and medical schools means poor care instead of good care. It is a disservice to veterans and a waste of tax funds. Yet, 10 of the 28 general medical and surgical hospitals now under construction by the Veterans' Administration are in such areas."

A United Medical Administration at least would enforce an organized plan for hospital locations, and stop the useless construction of hospitals in places where they cannot be properly staffed.

Also, when considering the subject of savings, there are other factors which must be taken into account.

For instance, the task force reported that on the basis of contracts let in 1948, the Veterans' Administration spent from $20,000 to $51,000 per bed for hospital construction, whereas voluntary organizations were able to build efficient hospitals for $16,000 per bed. Regardless of whether veterans' hospital costs have declined since 1948, or whether a per-bed cost is a legitimate basis for comparison, certain other findings of the task force in this respect cannot be ignored. For example, the task force reported that veterans' hospitals are built according to specifications laid down, not by the chief medical officer, but by the Veterans' Administrator, and they often include recreation halls, auditoriums, large dining rooms for ambulatory patients, offices for veterans' organizations and considerable office space for Veterans' Administration finance, records, claims, and other functions not strictly medical.

The length of hospital stays also figures into the medical bill. The task force's survey showed that whereas a patient remained in a voluntary hospital about 7 days after an appendectomy, a Public Health Service patient or a veteran stayed an average of 11 days and a military patient 19 or 20 days. The stays for tonsillectomy ranged from 1.4 days in a voluntary hospital to 16 days in an Army hospital. In the military hospitals which were checked, 75 to 85 percent of the patients were ambulatory. Hospitalization far from home, admission without proper diagnosis, waiting for the periodic visits of consultants and waiting for the untangling of red tape incidental to hospital discharges were some of the reasons found for longer stays at Federal hospitals.

In brief, a United Medical Administration, as provided in H. R. 5182, could integrate hospital planning, medical diagnosis, and convalescent facilities. The bill would also eliminate the out-patient services of regional offices of the Veterans' Administration. Regional offices provide clinical treatment for service-connected disability cases and examine pension claims matters. Much of this regional office work duplicates the out-patient service provided by veterans' hospitals. The rest of it could be contracted for from private physicians. Nevertheless, it is argued with some logic that the Veterans' Administration could function more efficiently by retaining its out-patient services, and the chamber would not oppose an amendment to H. R. 5182 which provides for such retention.

2. CIVIL DEFENSE NEEDS

The allocation of doctors between the military and the civilian population would be an extremely difficult problem in the event of war. There was a scarcity of doctors during World War II, during which the civilian population escaped epidemics and enemy attack. We must not presume on such good fortune in case of another war.

A single Federal hospital system could be adapted to civil defense needs much more quickly than could several systems. And with duplications eliminated, we could be assured of maximum use of medical talent from the outset of a conflict.

3. SERVICE TO VETERANS

Dr. Magnuson, the Chief Medical Director of VA, stated recently that 26,000 veterans with non-service-connected ailments have applied for, and are awaiting, hospitalization. Veterans' Administration hospitals have bed space, but not the medical staffs to care for many of them immediately. And yet, ade-

quately staffed military hospitals, some of them probably located in the waiting veterans' home towns, are considerably less than filled to capacity.

A United Medical Administration could immediately provide facilities close to home for thousands of additional veterans.

Some fears have been expressed that the quality of treatment now being provided for veterans with service-connected disabilities might be impaired by unification of the Federal medical services. The National Chamber believes that such fears are groundless. Veterans with service-connected disabilities are protected by statute. Their preference is guaranteed. A United Medical Administration would have to give prior attention to such veterans, to whom our Government owes its greatest obligation, and the Administration would have all the medical resources of the Federal Government at its command to use in discharging this responsibility.

4. VETERANS' BENEFITS

The veterans' right to hospitalization would in no way be interfered with by the passage of H. R. 5182. The Veterans' Administration would continue, as now, to certify him for hospital care, and would be responsible for determining that the care was provided. The Veterans' Administrator would serve on the Medical Administration's Advisory Board, for the specific purpose of safeguarding the veteran's interests in over-all planning.

5. CARE OF MILITARY PERSONNEL

Military hospitals, especially the smaller ones, are handicapped by a shortage of medical specialists. In New Orleans, for example, at the time of the task force study, there were five Federal hospitals. Two were large modern plants staffed by a total of about 100 full-time doctors representing all the medical specialties and backed by able local consultants. The other three were small military hospitals so poorly staffed that patients requiring specialized treatment had to be sent to other military hospitals in Texas or Florida.

A pooling of medical resources would provide uniformly better treatment for members of the armed services. It would also give military doctors an opportunity to improve their skills by working with civilian specialists associated with teaching medical centers. It would permit more professional mobility. A Veterans' Administration doctor, for example, would not have to spend all his time looking into patients' mouths for tonsils.

6. CONSERVATION OF MEDICAL TALENT

A waste of medical talent is inherent in the operation of four or five hospital systems.

By combining the job and spreading the work more evenly; by grouping doctors into one system of specialized centers; by making greater use of part-time specialists the way the Veterans' Administration recently has been doing; by closer association with medical schools and teaching hospitals, this wate can be largely eliminated. A United Medical Administration would provide such remedies.

7. CHRONIC DISEASES

Tuberculosis and neuropsychiatric diseases fill 60 percent of Veterans' hospital beds. Specialists in these diseases are scarce. Yet, the Federal agencies affected by this bill, as well as the Bureau of Indian Affairs, operate separate tuberculosis hospitals. There is no coordination of the agency programs and no integration with Federal, State, and local organizations for control of the disease, which has public health, social and economic, as well as medical implications. Each of the agencies also has its own planning staff for treatment of neuropsychiatric disorders and, in some cases, two Federal neuropsychiatric hospitals may be located in the same city. Evidence of the seriousness of this problem is found in the report of the Metropolitan Life Insurance Co., which made an actuarial study for the task force. The report predicted that 250,000 beds would be needed by 1975 just to care for veterans with service-connected disabilities and for chronic, non-service-connected cases who would be in nearly all cases medically indigent. Of these 250,000, the report predicted that three-fourths would be mental cases. H. R. 5182 would make possible the integration of, planning for, and the treatment of, this ailment. The Veterans' Administration now is per-

mitted by law to provide out-patient service only for service-connected cases. Congress well might consider extending the service to all veterans with neuropsychiatric symptoms and thus save costly hospitalization later.

8. INTEGRATION WITH NONFEDERAL SYSTEM

The private hospital system of this country generally is inadequate. Under the Hill-Burton Act, Federal aid is provided for non-Federal hospitals to help relieve this condition. Yet, various Federal hospital systems are competing with private hospitals for medical talent.

The steady growth of the Federal systems also weakens local support for the construction of community hospitals, and these community hospitals, many of which are affiliated with medical schools, are the training grounds for doctors on whom the Federal Government depends for its personnel.

H. R. 5182 would provide a single planning agency which could take better account of local and regional requirements and coordinate the Federal-aid program with the hospital system.

9. MEDICAL RESEARCH

Federal medical research needs to be more closely coordinated with public-health activities. There is need of a central plan for the various categories of Federal health grants and for the health activities of Federal agencies in such fields as nutrition, environmental sanitation, industrial health, and health education.

A United Medical Administration would serve this purpose.

10. MEDICAL SUPPLY

The Federal hospital systems have different arrangements for buying and storing medical supplies, and different specifications for them. In the Veterans' Administration, the supply service is wholly independent of, and on an equal basis with, the Department of Medicine and Surgery, despite the fact that extensive professional knowledge is needed to regulate the specifications and the handling of doctors' tools, and to keep abreast of the changing techniques of the medical profession.

A United Medical Administration could catalog and pool the purchase of supplies, reduce inventories, and eliminate some medical depots.

CONCLUSION

In conclusion, the Chamber of Commerce of the United States believes that H. R. 5182 would lay the groundwork for a reorganization of Federal medical services that would provide uniformly better treatment for all categories of Federal medical patients, improve the hospital system of the Nation generally, strengthen the medical defense we will need in time of emergency, and result in vast savings of public funds. We find nothing in this bill that is inimical to the interest of veterans, members of the Armed Forces, or Public Health Service patients.

Some criticism of H. R. 5182 has been based on the fact that the Surgeon General of the Public Health Service is not included as a member of the proposed Medical Advisory Board. It is my understanding that the Commission on Organization had in mind a probability that the Surgeon General of the Public Health Service would be appointed Administrator of the proposed United Medical Administration. I suggest that the committee might consider amending the bill so as to insure that the functions of the Public Health Service are not subordinated.

And now, Mr. Chairman, unless the committee wishes otherwise, I will dispense with the reading of the appendix to my statement in order to save the committee's time. I ask, however, that the full statement be included in the record of these proceedings, and I wish to express my appreciation for the opportunity to appear before you in behalf of this important national issue.

APPENDIX

The chamber's technicians and research facilities were made available to the task forces when the Commission on Organization began its studies. Then, as the Commission's reports were submitted to Congress, the chamber supported

most of them on general policy statements which long have called for more efficient and more economical operations in Government. This support was given in advance of the adoption of a more specific policy in the spring of 1949.

The following policy was adopted at the annual meeting of the Chamber of Commerce of the United States in 1950:

"There is increasing need for thoroughgoing reorganization of the Executive Branch of the Federal Government in the interests of economy and efficiency.

"The effectuation to the greatest extent practicable of legislation based on recommendations of the Commission on Organization of the Executive Branch of the Government should be encouraged by wide public support.

There should be energetic legislative and administrative actions necessary to the realization of the intent of the Congress as expressed in the act creating the Commission. Of particular importance at this time is legislation which would consolidate the Federal medical service, modernize the postal service, place the accounting of the Government on a businesslike basis, overhaul the obsolete Federal personnel system, and give better service to our veterans by reorganizing the functions of the Veterans' Administration. Other important measures which remain to be acted upon are those reorganizing the agricultural and natural resources activities of the Federal Government.

These measures aim to promote governmental economy, efficiency, and improved service in the transaction of the public business through better execution of the laws, more effective management, and expeditious administration; reduction of expenditures; grouping and coordination of governmental functions according to major purposes; elimination of duplicating; overlapping or unnecessary functions or agencies; and careful definition and limitation of executive functions, services, and activities. If these measures are enacted and vigorously executed, vast savings are possible.

In the interest of improving the structure and operation of the Federal Government and the conduct of needed activities in the most efficient and economical manner for accomplishment of essential results, the chamber should make every effort to develop public support for measures needed to realize these purposes and aims.

The CHAIRMAN. Our last witness will be Mr. Robert L. L. McCormick. He is very well known to us, and is the research director of the Citizens Committee for the Hoover Report. Mr. McCormick.

STATEMENT OF ROBERT L. L. McCORMICK, RESEARCH DIRECTOR, CITIZENS COMMITTEE FOR THE HOOVER REPORT

Mr. McCORMICK. Mr. Chairman. Before I commence with my prepared statement I would like to comment first that I was very interested in the testimony of Dr. Clarke, and I would like to point out that there is not too much difference between the Department of Health that he is for and the United Medical Administration that we are for.

The CHAIRMAN. I think there is a great difference between them in regard to the Armed Forces. I think you will find the Armed Forces and the Veterans' Bureau set-up in this UMA is the thing that is giving the most trouble. He is not for the taking out of the Armed Forces and the Veterans' Bureau their medical activities.

Mr. McCORMICK. I think, sir, the Department of Health would in the long run tend almost automatically to become very little different from a United Medical Administration. That is my opinion on it, sir.

Secondly, sir, I would like to point out that, as this committee knows very well, I am not an expert in all of these dozens of subjects on which I testify. I am rather like Jim Thorpe at times. I take my football suit off and put my baseball suit on.

In this case I am not arguing myself. I am just attempting to expound the views of the task force, those of Gen. William C. Menninger, M. D., the Menninger Foundation, Topeka, Kans.; Gen. Paul R.

Hawley, M. D., former Chief Surgeon, European Theater of Operations and former Director of Medicine and Surgery, Veterans' Administration; O. H. Perry Pepper, M. D., professor of medicine, University of Pennsylvania, Philadelphia, Pa.; Edward D. Churchill, M. D., professor of surgery, Harvard medical school, Harvard University, Cambridge, Mass. and former president of the American College of Surgeons; Hugh J. Morgan, M. D., professor of medicine, Vanderbilt University, Nashville, Tenn., and former president of the American College of Physicians; Ray Lyman Wilbur, M. D. (deceased), former president of Stanford University, Palo Alto, Calif., and formerly Secretary of the Interior; and others. It is the report that they wrote. I am merely here as a convenient local spokesman for the views they expressed in writing.

My name is Robert L. L. McCormick. Dr. Robert L. Johnson, chairman of the Citizens Committee for the Hoover Report, requested that I present the committee's views on H. R. 5182, in my capacity as research director for that committee.

POSITION OF THE CITIZENS COMMITTEE

It is the purpose of the United Medical Administration bill, H. R. 5182 (S. 2008), to meet the immediate, tremendous need for over-all planning and central coordination of our enormous and expanding Federal medical activities.

In the confusing and costly absence of any central plan, or any central supervision of Federal medical activities, the United States Government, to quote the Hoover Commission report, is—

> moving into uncalculated obligations without an understanding of their ultimate costs, of the lack of professional manpower available to discharge them, or the adverse effect upon the hospital system of the country.

The United Medical Administration bill carefully and judiciously provides for an organization charged with the specific responsibility for over-all planning and central supervision of our many Federal medical activities. The inseparable objectives of this bill are to unite the medical functions now in five major agencies in order to (1) eliminate overlap, waste, and inefficiency in programing; and (2) insure that Government medical care and research be of the highest quality and a model for the Nation. The proposed form of organization is a unification in which each of the major agencies would have an advisory voice in management.

The United Medical Administration bill was drafted by counsel for the Hoover Commission. It embodies the major specific recommendations of that Commission for organization of Federal medical services to provide for over-all planning and for execution of these plans. The Citizens Committee for the Hoover Report endorses this bill, H. R. 5182 (S. 2008) as a necessary and workable solution to a vital and extraordinarily complex Government problem. The Citizens Committee endorses H. R. 5182 (S. 2008) as being in the highest public interest. We will, however, supply your committee with perfecting amendments. In short, I am appearing in support of this bill.

THE NEED FOR A UNITED MEDICAL ADMINISTRATION

Our Federal Government is spending a tremendous amount of money (nearly $2,000,000,000 annually) on its medical programs, and

it is using a high percentage of that manpower in the Nation which is skilled in administering health. Yet, with all this dollar and manpower outlay, the tubercular veteran is told there is no hospital bed for him, the phychiatric is told he can only be "put on the waiting list."

The situation is that the public is supporting an enormous Federal hospital, medical, and health program, without receiving the services thereby intended to be provided. This unfortunate situation is not necessary. It is due to poor organization.

LACK OF OVER-ALL PLANNING IS ROOT OF MEDICAL-PROGRAM PROBLEMS

There is a complete lack of over-all planning and central supervision of our $2,000,000,000 annual Federal medical activities. This absence of planning, and the excessive preoccupation of each of the five major agencies with the operation of its own independent medical program, is the real source of our Federal medical problems. (The essence of the UMA bill is to fill this void by providing the framework for over-all planning and central supervision of our several medical and hospital programs.)

It is a fact that the present operation by each of five major agencies of its own medical and hospital program has resulted in an unfortunate, needless, and excessive expenditure of money in the duplication of facilities at the expense of the public, when proper care is not being afforded to those entitled to it.

It is also a fact that each of the five agencies obtains public funds and builds hospitals without adequate knowledge of, or regard for, the existing facilities, case loads, and needs of the other agencies.

It is recognized that each of the five agencies compete with each other—and with the community in which they locate—for scarce professional and technical personnel.

It is increasingly clear that Federal hospital and medical programs have a tremendous and unfavorable impact on community facilities. There is also a glaring inconsistency between the Government's policy to aid non-Federal hospitals and its policy to construct Federal hospitals without reference to community facilities.

There is insufficient provision for research into all phases of preventing and curing diseases. Expenditures for research are less than 4 percent of total expenditures for medical care, and even those are not planned on a unified basis. There is insufficient provision for the exchange of discoveries in research and in the use of expensive equipment.

Each of these deficiencies is inherent in the present methods employed by the Federal Government in administering its medical programs. The deficiencies can be traced directly back to a lack of over-all planning.

DUPLICATION OF FACILITIES

The complete preoccupation of each of the five agencies with its own medical program, together with the lack of adequate facts and figures on which to base prudent planning, have led in many cases to expensive and needless duplication of Federal hospitals.

A commentary on the lack of planning involved in our expensive hospital-construction programs is the conspicuous absence of any

single Federal source of authoritative statistics on the number and utilization of all Federal hospital beds.

Likewise, there is a lack of a single source of authoritative statistics on the present need and future requirements for Federal hospital beds.

A citizen of our $40,000,000,000 Government cannot find definitively—in print—and we know this, because we have been trying for months:

(1) How many active and inactive hospital beds it has.

(2) How many patients are in them.

(3) What patient loads are expected over the near and long term.

(4) How much money is being spent for medical research—and where—and why.

(5) Comparative operating costs, per bed, per doctor, and per patient for all Federal hospitals.

(6) How each community of our Nation is equipped to handle present and potential hospital requirements.

(7) What manpower is and will be available to staff present and potential hospital requirements of the Government and of State and private institutions.

In view of the basic and fundamental nature of these statistics, and the elemental need for them in planning, it is a serious indictment of the present method of administering medical and hospital programs that these statistics are not readily available.

There is significant and important evidence that the presently authorized hospital-construction program has not been sufficiently considered in relation to all existing hospital facilities—Federal and community.

Mr. RICH. Mr. Chairman, may I just ask Mr. McCormick this question: With regard to the list of seven questions that you state you are unable to get the information on, has the committee of which you are a member and representative tried to find out and tried to get that information from the present Government?

Mr. MCCORMICK. The Hoover Commission, sir, did obtain most of this information. What they obtained is the only authoritative source now and their figures are almost 2 years old now. We have obtained some of the up-to-date information, but we have not obtained all of it, because it does not exist in readily attainable form.

Mr. RICH. You mean they do not keep a report giving you that information?

Mr. MCCORMICK. They keep certain private figures, sir, on some of these matters. They do not have any on others.

Mr. RICH. Is that because of the fact that we have no coordinating department in the health and education branch of our Government?

Mr. MCCORMICK. It is because nobody is responsible.

Mr. RICH. Mr. Warren, the Comptroller, told us there were 28 different divisions of Government now dealing with health and education. With those 28 departments, you still cannot get the information that you have asked for?

Mr. MCCORMICK. You can get a considerable portion of this information from the individual ones, sir, but you cannot find it in any one place. You cannot get it on the comparable established bases so that it can be compared.

Mr. RICH. Then it shows that we have a very poor administration in the Health Department of the Federal Government.

Mr. McCORMICK. Well, no one is responsible for this—as we read the present laws.

Mr. RICH. Nobody is responsible?

Mr. McCORMICK. Not under the laws now on the statute books.

Mr. RICH. What kind of an administration have we if we are not responsible.

Mr. McCORMICK. The individual agencies are responsible but I do not think anybody is responsible for any over-all management. It is a defect in the laws, and not in the present administration. It was probably equally true when Mr. Hoover was in office.

The CHAIRMAN. While you have stopped in reading your statement, may I ask you to name the five agencies you referred to, that is, the five major agencies?

Mr. McCORMICK. The five principal agencies involved in this, sir, are the Federal Security Agency; the Departments of the Army, Navy, and Air Force; and the Veterans' Administration.

The CHAIRMAN. Do you count the Defense agencies as one?

Mr. McCORMICK. No, sir; they are counted as three.

The CHAIRMAN. And the last one is what?

Mr. McCORMICK. The Veterans' Administration.

The CHAIRMAN. Do you mean to say that the Federal Security Agency cannot give you the numuber of empty beds, and the number of beds occupied, and the number of hospitals under its jurisdiction?

Mr. McCORMICK. They can give it for those beds subject to their own jurisdiction.

The CHAIRMAN. And the Army can do the same?

Mr. McCORMICK. Yes.

The CHAIRMAN. And the Navy can do the same?

Mr. McCORMICK. Yes.

The CHAIRMAN. And the Air Force can do the same?

Mr. McCORMICK. Yes, sir.

The CHAIRMAN. And the Veterans' Administration can do the same?

Mr. McCORMICK. But the figures these agencies offer are not comparable statistically.

The CHAIRMAN. So it is just a matter of contacting these five agencies, if you wanted to know the number of beds, and from each one you can get the number of beds occupied and unoccupied. Then, through the simple method of addition, that will give you the number of occupied beds and the number of empty beds for the entire Federal medical set-up, would it not?

Mr. McCORMICK. No, sir. Some of the figures they give you are not at all comparable—and we question their accuracy.

The CHAIRMAN. What one agency will not give you the number of occupied beds, if they have hospitals under their jurisdiction? Tell us, and we will get those figures for you, if you will name the agency.

Mr. McCORMICK. They do not know, in some cases.

The CHAIRMAN. They do not know the number of beds, and do not keep records on them from month to month?

Mr. McCORMICK. The services do not.

The CHAIRMAN. Which one of these five agencies does not know that?

Mr. McCormick. I will give you an example. For example, the Budget Bureau is unable to obtain——

The Chairman. Let us deal with these five agencies that you say are the five major agencies. Which one of those will not give you the information?

Mr. McCormick. In the official statistics——

The Chairman. I am not talking about official statistics. You say that these records are 2 years old, and they did give them to the Hoover Commission, and the Hoover Commission had them, but now those figures are 2 years old and you cannot get the new figures.

Tell me which one of these agencies will not give you that information.

Mr. McCormick. They are all willing to give us the information, sir, but the information is not printed, or publicly available; nor is it comparable because they use different types of beds and have different types of hospitals, and, in some cases, they do not report all of the beds that are unoccupied.

I will give you an example. In the case of the Navy, certain hospital beds, at Great Lakes, I believe, are not indicated in their statistics. They give you the figures of what they call beds that are "activated," but then they have another category of beds that are "deactivated."

The Chairman. That is right. If they have discarded a hospital and it is not on active duty——

Mr. McCormick. It could be right in the same hospital, sir.

The Chairman. Well, we will say that they discarded a section of it, and that it is not being used, or that it is not being used as a hospital. Certainly they would not give you a deactivated hospital, or a portion of such a hospital, as being among the current number of beds available, and they would not show them as being occupied or not occupied. I do not think anybody would do that.

Mr. Roosevelt. His point is, Mr. Chairman, that the Veterans' Administration might use a different set of statistics. In other words, they might give you all the beds, both activated and deactivated. Therefore, he, as a searching citizen, cannot correlate the two, because the basic definition is not the same in the various agencies.

Mr. McCormick. That is right.

The Chairman. The answer to that is found in one question: Are all these beds activated?

Mr. Roosevelt. I agree with you.

Mr. Rich. I might state here that the the chairman of our committee is a very smart and bright man.

Mr. Roosevelt. I concur.

The Chairman. I object to the compliment.

Mr. Rich. But, can he answer this question: It is stated that the Army discontinued the use of thousands and thousands of beds that the Veterans' Administration says they need. Now, why can you not coordinate that? If you want to protect this administration, you just tell me why they are doing such foolish and crazy things as that.

The Chairman. It is not my role to protect this administration, but it is my role to be interested in the functioning of our Government and to find out how it can be improved, and what should be eliminated, or what should not be eliminated. We can all appreciate that there

are many hospitals that are not now in use, because we have just come out of one of the greatest world wars that we have ever had. During that period it was necessary to build hospitals temporarily, and to provide beds in places where troops were located. Oftentimes troops were located far from the large centers of population. Now, when we come back to peacetime——

Mr. RICH. My dear brother, if you would be interested in the administration and take the part of trying to take care of that situation——

The CHAIRMAN. I am a Congressman in it, and you are, too.

Mr. RICH. But you ought to be down there in the Department running the thing, and then we would have efficiency and good Government; but here you are only one of 435, and you cannot do it. Get a Presidential appointment, and we will have success.

Mr. HUBER. These figures are 2 years old, Mr. Chairman. Of course, that goes back to the Eightieth Congress, with all of its inadequacies.

The CHAIRMAN. The Hoover Commission was a bipartisan Commission, set up under the Eightieth Congress, and it was one of the finest accomplishments of any session of Congress, I think, that we have had in many and many a day. But, it was bipartisan.

Mr. MCCORMICK. Mr. Chairman.

The CHAIRMAN. Yes, Mr. McCormick.

Mr. HARVEY. If I might interject a point there, this came to my attention recently, and it is right along this line. Billings Hospital is an adequate hospital, and is operated in conjunction with Fort Harrison, just at the edge of Indianapolis. It is an adequate hospital as far as the construction is concerned, and I am unable to quote the figures, although I can supply them. However, they have a large hospital there. I think it is a 500-bed hospital. It is being deactivated, and they are going over and building another hospital, which is comparable to that, at a cost of around $7,000,000, simply to get a few miles closer to the Indiana University Medical Center.

The Billings Hospital is at one edge of Indianapolis, and they are junking that now.

The CHAIRMAN. The Army, the Navy, or the Veterans' Administration?

Mr. HARVEY. It is presently used by the Veterans' Administration. They are building another Veterans' Administration hospital of the same capacity, just in order to have it closer to the medical center.

I can understand in this particular instance the value, of course, of having a hospital located geographically near the medical center. However, the thing that has appealed to me in this instance is that we are confronted with the decision of spending $7,000,000, and we realize that we have a tremendous shortage of public tax funds. Spending that money at this particular stage of our hospital program would not be well advised.

The CHAIRMAN. I think that is why, after the Congress had authorized the money to build that kind of set-up, the President stepped in. He did not veto the bill but has held up the money in order to keep that very thing from happening. The Congress authorized the

building and appropriated the money for it, and it has only been held up by Presidential order.

Mr. RICH. I supported the President on his veto, and supported him all along on doing that very thing. I am against the construction of hospitals in the State of Pennsylvania now, when we have a hospital at Valley Forge that will take care of 1,800 people. There is no use in building another hospital in Pennsylvania and paying out $10,000,000, or $15,000,000 or $20,000,000 for the construction of it, until we occupy that hospital which is already there.

The CHAIRMAN. But we voted on it.

Mr. RICH. I know, but there is where the Congress was wrong. I say that you ought to be a Presidential appointee and not a Congressman.

The CHAIRMAN. You tell the President that. I appreciate that, sir.

I think we should scrutinize most closely our appropriations. I think Mr. Roosevelt is doing a great work in setting up a new system of budgeting.

Mr. HUBER. Does not the responsibility for that action rest with Congress? It does not rest with the administration but with the Congress.

Mr. HARVEY. I think it bears investigation. I want to go ahead and say that I was not criticizing anyone particularly, I am not saying whether it is the fault of the Congress or the Veterans' Administration. I am unable to say who was responsible for making that decision, but I do know the situation exists; and if it is Congress' fault, of course, it should be condemned.

The CHAIRMAN. I do think this, too, Mr. Harvey: Our committee has the power of looking into the expenditures and the money appropriated; and, if there is any situation that is drastic or grave, I think it would be this committee's duty to look into that.

Mr. HARVEY. I think so. I think it frankly is. As I explained, Mr. Huber, in this particular instance I was not disclaiming the advantage that would come from having a hospital located adjoining the medical center instead of being at the other edge of the city of Indianapolis.

Mr. HUBER. I appreciate that.

Mr. HARVEY. But I do say that, when you are confronted with the necessity of having to make such money as you have go as far as it can, I believe that the same amount of money could have been spent and you could have achieved a hospital with 500 additional beds, because in this instance you are not going to gain a thing. You will still be where you were when you started from the standpoint of gaining extra beds.

The CHAIRMAN. If we are through, we will let the witness proceed.

Mr. MCCORMICK. We have prepared a complete bed study which, as far as I know, is the only one available in this country, but we have not put it in this testimony because there were many thousands of beds that, due to the lack of decent statistics, we were not able to find, until very recently. However, we have now found all the missing beds.

On page 6, at the top, I would like to insert this table of mine, and I will not read it.

(The table referred to is as follows:)

The table below points out where Federal hospitals are to be built in five areas where other Federal hospitals are currently being closed.

Planned VA hospitals	Type	Beds	Military hospitals being closed	Operating beds January 1950	Occupied beds January 1950
Boston, Mass	GMS	1,000	Murphy General, Waltham, Mass	715	560
Brockton, Mass	GMS	1,000			
Philadelphia, Pa	GMS	500	Valley Forge General, Phoenixville, Pa.	1,650	1,300
Atlanta, Ga	GMS	500	Oliver General, Augusta, Ga	1,500	1,030
Ann Arbor, Mich	GMS	500	Percy Jones General, Battle Creek, Mich.	1,200	970
Los Angeles, Calif	NP	1,000	U. S. Naval Hospital, Long Beach, Calif.	1,500	1,100

NOTE.—All above-listed Army and Navy hospitals are "General" hospitals corresponding to VA's GMS category.
GMS = General medicine and surgery.
NP = Neuropsychiatric.

Mr. McCORMICK. It is an expensive irony, and a policy hardly in the highest public interest, that there is unused bed capacity in our Federal hospital system (some large general hospitals are even being closed down); at the same time that a billion dollar Federal hospital construction program is under way.

A case in point is the 500-bed Veterans' Administration hospital now under construction in Philadelphia. This hospital will cost nearly $7,000,000. Following the war, the Veterans' Administration wanted to take over the Army's Valley Forge Hospital at Phoenixville, Pa.—about 25 miles from Philadelphia—but the Army decided to keep it as a permanent installation. As late as October 1949 the Army reiterated its decision to keep Valley Forge. So the Veterans' Administration, which badly needed a veterans' hospital in the Philadelphia area, went ahead with plans to build a 500-bed unit there.

Contracts were let in December 1949, and construction started the next month. Then, in February 1950, the Army changed its mind and decided it did not need Valley Forge after all. But this was too late. Construction on the Veterans' Administration hospital was then well under way—and at a cost of nearly $7,000,000.

Mr. ROOSEVELT. That is just what you were referring to, is it not, Bob?

Mr. RICH. That is what I am talking about, and I think we would make a great mistake, even if we need hospitals in the western part of Pennsylvania now. I am in favor of opening up the Valley Forge Hospital and utilizing that, without spending $7,000,000 to $10,000,000 some place else, in order to build hospitals. I feel that we are only doing our duty there, just as our chairman stated a while ago. I wrote him a note and told him if he would get behind that and push that thing through, that I think he could do it.

The CHAIRMAN. Put me in the Department of Welfare.

Mr. RICH. I hope you fellows on that side of the table here will help to do that.

Mr. McCORMICK. We do not say that that situation is anybody's fault, but it is just that nobody is responsible for it by law.

The American Hospital Association recognized the dangers of Federal hospital construction without central and integrated planning in

its report, Federal Hospital Planning with Particular Reference to Care for Veterans, dated May 1950. It stated:

> With the gradual unfolding of the governmental program for the establishment of hospital facilities throughout the United States, it becomes increasingly apparent that there is a definite need for coordinated planning to assure the realization of all desirable objectives. * * *
>
> On the other hand, development of the Veterans' Administration program has proceeded on the basis of minimal integration with other Federal hospital systems and none whatever with the non-Federal hospital system.

Mr. RICH. I might state here, Mr. Chairman, that I believe our discussion here about the hospitals has caused me to see the real need for somebody to look after this hospital situation, and that is the more imperative now because we have discussed the fact that we find out that we cannot lay our hands on somebody who is responsible for permitting these hospitals to be vacated, and other new hospitals to be built. I am convinced now, more than ever, that something should be done.

Mr. MCCORMICK. Thank you, sir, I will continue with my statement.

COMPETITION FOR AND EXTRAVAGANT USE OF LIMITED MANPOWER

The current practice of the five agencies administering medical services to compete with each other, and with the communities of the Nation, for doctors, dentists, nurses, and technicians, has greatly aggravated the present shortage of such personnel.

There is a shortage of competent professional personnel that appears to be neither temporary nor self-correcting. Both Federal and community hospitals find it difficult to get necessary professional and technical personel to service their capacities and clientele. Internships are not being filled in many places. In this regard, the American Hospital Association stated in its study, Veterans' Hospitalization Planning of May 1950:

> This competition between the Government and the civil interests is making it difficult to properly staff community hospitals with professional personnel. In fact the situation has become critical. Hundreds of intern vacancies are reported each year and nurses are in short supply.

Our limited skilled manpower is not, and cannot be, utilized to the highest extent under the present separation of Federal medical activities.

The CHAIRMAN. Are you talking about trained personnel now?

Mr. MCCORMICK. Yes, sir, trained medical and technical personnel.

The output of our medical and technical schools is limited. There is no adequate provision for assignment of specialists, for example, from one agency to another, requiring a particular talent at a particular time. Present immobility of our limited skilled manpower works a disservice both to the medical programs and to the individual. Mr. Eli Ginzberg, associate professor of economics at Columbia University, who testified on H. R. 5182 before the House Expenditures Committee on June 14, estimated that in World War II "an integrated medical service for the Army and Navy might have resulted in reducing requirements for medical personel by a quarter, or possibly even a third."

The five agencies as presently organized have no means of coping with the manpower shortage, other than by accentuating competition between themselves and with community institutions. This fact em-

phasizes a cardinal weakness of the present Federal organization for medical care is its failure to provide for coordinated personnel planning, procurement, and utilization.

The danger associated with the lack of central planning for medical services is evidenced also in the present policy of constructing hospital capacity far in excess of manpower to service that, or even existing capacity.

IMPACT ON COMMUNITY FACILITIES

The complete lack of central planning for a national hospital program, inherent in our present Federal medical structure, is causing great injury to our community hospital system. Lack of Federal planning has resulted in competition between tax-supported Federal hospitals and community hospitals, which are already in great financial difficulties.

The impact of Federal hospital construction, particularly VA hospitals, on the community hospital system is tremendous. Federal hospitals siphon off nursing and other scarce personnel, particularly through salary differences.

The CHAIRMAN. Does the Government pay more than private institutions?

Mr. MCCORMICK. In many cases it does pay higher salaries, particularly for the lower technical levels.

Mr. RICH. May I ask you the question as to whether it is not the fault of the people who are in the educational system of our country, and who are requiring these high standards for the profession of nursing, and making it so difficult to secure the personnel that can maintain that high standard? It sometimes seems to me that we just go beyond the point of good, sound business.

In other words, if you expect everyone to wear a Phi Beta Kappa key, it just can't be done. I think that the medical profession, in the nursing field, has a shortage because it is so difficult to become qualified for the work. I think they have gone beyond the pale of good, common sense in that respect.

I might cite this illustration: Take my business, for example. A lot of fellows who never reach more than the eighth grade in school are the very best men you have in the manufacturing field. Many boys who wear Phi Beta Kappa keys and who are college graduates, are not nearly as good in the manufacturing field as the eighth grade boys—and they are not getting the salaries of the eighth grade boys, by any stretch of the imagination.

The CHAIRMAN. You are not against higher education, though, are you?

Mr. RICH. I am not one who advocates the necessity of wearing a Phi Beta Kappa key in order to become a nurse.

Mr. ROOSEVELT. You do not want to imply by that statement that big business operates on the level of the fifth or sixth grade, do you?

Mr. RICH. No, I do not. I think they are just as good, as clean-cut, Christian and hard working if they come out of the eighth grade as the fellow who wears a Phi Beta Kappa key. They do not know as much about Latin and Greek, and some of the other subjects, which I do not think contribute very much to the welfare and well-being of our national life.

The CHAIRMAN. I think you have something there. Will you please proceed?

Mr. McCORMICK. At the same time, VA hospitals reduce the income of community hospitals by taking away a large class of patients—about 14 percent of the community population—many of whom would normally come to them.

The CHAIRMAN. Why is that true? Do they take the people into the Veterans' Administration hospitals who are not entitled to be there?

Mr. McCORMICK. It is because of the prohibition in the law, I believe, against any investigation of the resources of people who sign the so-called "pauper's oath." I cannot take any position in that.

The CHAIRMAN. In entering the hospital, do they not have to have some connection with one of the services under the laws passed by the Congress?

Mr. McCORMICK. Yes, sir; but many of the veterans who go into Veterans' Administration hospitals—I know of one man in my own community, for example, who was ill. He could perfectly well afford to pay it, but he went into the Veterans' Administration hospital and he signed his name to the "pauper's oath" and went right into the veterans' hospital.

The CHAIRMAN. Was he a veteran?

Mr. McCORMICK. Yes, sir; but he could have perfectly well paid for it, and if anyone had questioned his pauper's oath, he could not have qualified.

The CHAIRMAN. Do you believe if a man was injured in the war, though he had a million dollars, he should not be entitled to the care given a veteran, even the poorest?

Mr. McCORMICK. This was a non-service-connected case, Mr. Chairman.

The cold fact is that while one Federal program (the Hill-Burton Act) spends $75,000,000 a year to build up community hospitals, another Federal program (the VA hospital-construction plan) will spend $1,000,000,000 to build separate hospitals and in effect compete with community hospitals.

We are not saying that the Veterans' Administration should not build the hospitals, but we say somebody should look at the thing to see that it makes sense.

The American Hospital Association points to the lack of integration between the Federal and non-Federal hospital systems in its following testimony before the Hoover Commission on October 28, 1948:

> We believe that there has been grievous lack of coordinated planning between the Federal hospital systems and, perhaps even more important, between all Federal hospitals and those which serve the balance of the population. There was an effort to provide some coordination through the Federal Board of Hospitalization. It is our impression that while the Board accomplished a degree of coordination, the present overlapping and duplication indicate that it was, in general, ineffective. We gather that the functions of the Federal Board of Hospitalization have been assumed by the Budget Bureau, and we are impressed that a sincere effort to correct some of the problems is being made by that agency. It is, however, our belief that accomplishment under present legislation by the Budget Bureau will be limited as compared with the opportunities and needs for coordinated planning to avoid overlapping and duplication.
>
> It is our belief that proper coordination of Federal, military, and civilian hospitals will only come about by the establishment of strong authority within the

Federal Government. Such agency should have some degree of operating responsibility and full responsibility for coordination of all Federal health services. It should have the responsibility for recommending to Congress any necessary steps to expand Federal hospital services in such a manner as to avoid waste and duplication.

Although both the Hill-Burton program and the VA hospital program are now in operation, and in some ways in contradiction, there is not at present any agency or any commission studying or working on the important problem of the relationship of the Federal to the non-Federal hospital program.

FACTS REGARDING OBJECTIONS TO H. R. 5182

At the hearings held on H. R. 5182 before your Committee on Expenditures on March 29, 9150, five witnesses testified. Their testimony, for the most part, was concerned with the veterans' medical program as established by Congress, rather than on the establishment of an agency responsible for over-all planning and central supervision of the several Federal medical activities which is the genesis of H. R. 5182.

The testimony given at that date would indicate that the medical program of the VA was on trial, which, of course, is simply not true. It is our contention that the United Medical Administration bill should be considered and debated on the real issue: Does the UMA meet the long outstanding need for over-all planning and central supervision of our enormous and expanding Federal medical activities?

TESTIMONY OF AMERICAN LEGION SPOKESMEN

The testimony of three witnesses, Commander George Craig of the American Legion; Dr. Leonard Rowntree, chief medical adviser to the American Legion; and Dr. Charles W. Mayo, member of the Mayo Clinic and the medical advisory committee to the American Legion, points up their preoccupation with the veterans' medical program established by the Congress, to the neglect of the problem of administering all Federal medical programs, which is the real issue and purpose of the UMA bill.

Actually, the testimony of these three witnesses raised few factual or serious objections to the bill and its purposes. Those serious and pertinent points which they did raise will be discussed herein, and the problem clarified by later amendments, insofar as we are capable.

It is to be expected that certain misunderstandings would arise over the bill itself. Unfortunately, discussions involving Federal medical programs are not as clinical as they properly should be. Many of the misunderstandings regarding H. R. 5182 result from the phraseology of the bill itself, or from a lack of knowledge of the over-all management problems involved in Federal medical programs as a whole.

The points raised by each of these witnesses and a discussion of those points on the basis of facts follow. It is clear that the basis for certain objections to the bill do not, in fact, exist, and that certain other objections can be removed by suggested amendment.

STATEMENTS MADE BEFORE THE HOUSE COMMITTEE ON EXPENDITURES AT HEARINGS ON H. R. 5182, MARCH 29, 1950

The national commander of the American Legion directed a considerable part of his testimony to the appraisal of the Citizens Committee for the Hoover Report. The Citizens Committee is scarcely the issue here.

Commander Craig also expressed concern for the future of the veterans' medical program which, of course, is not the subject of this bill which deals only with organization and administration of medical activities which are established by law by Congress. Under this bill, the veteran medical program, naturally, remains intact. The bill simply brings it under the framework of a central agency where the veterans' program would get the benefits of the advantages of better planning for necessary construction, procurement of professional technical personnel, and the general advantages of central supervision.

Commander Craig made certain statements which require discussion:

> Under the proposed UMA there would still need to be the VA and the veterans to be cared for, though H. R. 5182 makes no provisions for such care.

H. R. 5182, on the contrary, specifically provides that the veterans' medical program would continue to be carried out, as established by law, under the UMA.

This bill does not change any laws that have been written by Congress except organizational laws.

The specific veterans' medical benefits and preferences are set down in statute, and, it is not, of course, proper or necessary to restate United States policies or programs in bills such as H. R. 5182, which deals solely with organization.

> Were H. R. 5182 to be approved, then one of two things probably would occur. You would either divide the existing records between the shell remaining of the VA and the new experimental UMA; or you would duplicate the existing records with all the delay that would entail.

H. R. 5182 carefully provides for ready availability of pertinent files to the Administrator.

In addition, the Citizens' Committee is preparing a perfecting amendment to H. R. 5182 which further centers responsibility for judicious transfer of files on the Secretary of Defense, the Administrator of Veterans' Affairs, and the Medical Administrator.

The present practice of the armed services in regard to transfer and carriage of medical records of veterans and of servicemen has been satisfactory. Under present practices, in the Army, Navy, and Air Force, personnel medical records are subject to transfer from station to station. The practice has worked out most satisfactorily.

I can say from my own case that the transfer between the Navy and the Veterans' Administration was also satisfactory. There is every reason to expect it would work out just as satisfactorily in this instance.

Dr. Charles W. Mayo, member of the Mayo Clinic and of the medical advisory board of the American Legion, testified briefly and confined his comments largely to concern for the status of the Public Health Service under the UMA. In view of conditions which have changed

in the year since the drafting of the bill, perfecting amendments will be submitted by the Citizens Committee on this point. This amendment should meet Dr. Mayo's objection.

The CHAIRMAN. May I ask, since this bill is under consideration, when those amendments are going to be presented?

Mr. McCORMICK. We have them all ready. We wanted to let Mr. Hoover and other experts look them over before we sent them in. I think we can get them in sometime next week. We will try to get them in the first of the week.

In the course of questioning, Dr. Mayo recognized the duplications of medical equipment, medical supplies, and medicines that exist under present conditions, and felt economy and efficiency could be achieved through a single purchasing agency. Dr. Mayo also felt that unification of military hospital facilities would eliminate duplications of facilities, staffs, and permit greater utilization of present limited facilities and personnel.

Dr. Mayo made the following statements:

We who have been associated with the VA feel that one of the most important steps which contributed to the present quality of medical care was the removal of doctors, dentists, and nurses from civil service. Bill H. R. 5182 would return them to civil service, and to this I am opposed.

H. R. 5182—the draft you have in front of you—does not return doctors, dentists, and nurses to civil service.

The CHAIRMAN. Does it include many doctors and nurses now under civil service?

Mr. McCORMICK. I cannot answer that definitively, sir.

The CHAIRMAN. Are nurses and doctors under civil service in the Public Health?

Mr. McCORMICK. It provides that the President can issue regulations defining the status of such people under section 1753 of the Revised Statutes, as amended, which are very broad.

The CHAIRMAN. But some of the doctors and nurses included under this are under civil service, so you would have some under civil service, and some who are not under civil service.

Mr. McCORMICK. They could and should, according to the recommendations of the Hoover Commission, be taken out, by administrative action of the President, after creation of the Medical Administration. We think, in passing, that it is a rather sad commentary on the civil service system, that it would be necessary to have to take them out. We have another bill for personnel covering that point.

The CHAIRMAN. The civil service requirements afford protection to those under it, and I do not think those under it are anxious to get out. We want a broader coverage under the civil service.

Mr. McCORMICK. The professional groups have rightly been very critical of civil service, sir. The bill provides for the retention of their present separation and degree of independence under the provisions of this bill (see p. 11, sec. 5 (g)). The Citizens Committee is submitting a perfecting amendment to this bill which directs the Administrator to give Congress, 1 year after enactment of this bill, a plan to consolidate the Public Health Service and the Department of Medicine and Surgery into a single unified professional health and medical career service.

The bill in question would take into the UMA lock, stock, and barrel, the Public Health Service, change its name, give it no representatives on the advisory board,

and make no provisions for the protection of the career officers of the United States Public Health Service such as is provided for officers of the Army, Navy, or Air Forces.

We feel that objection is valid. We did not intend the bill should do that as completely as it seems to do it on second reading, as we have frequently found in skeletal bills presented. We believe this objection can be completely eliminated by perfecting amendments which we will submit, as we have in every other instance. They would cover the identity of the Surgeon General and the Public Health Service. These would remove the objection that the Public Health Service is neglected and not adequately represented.

Secondly, it would provide for protection of the career officers of the Public Health Service. The United Medical Administration would be responsible for submitting recommendations on establishing a single unified professional health and medical career service within 1 year after enactment of this bill.

Dr. Leonard Rowntree, chief medical adviser to the American Legion, devoted his testimony to the present operation of the medical program now under the Veterans' Administration. Dr. Rowntree defended, in fact, what is not and cannot be the issue in the consideration of this bill. Dr. Rowntree expressed fears for the continuance of the medical program and preference for the veteran. Congressman Holifield rightly pointed out to the doctor that no function or no service to the veteran would be abolished by this bill.

Dr. Rowntree's fears and anxieties may be removed with his realization that the purpose of this bill deals with organization and not with policy. Government policy in regard to any medical program, including the veterans' program, is beyond the purview of this bill.

The preoccupation of each agency with its own medical program is clearly indicated by Dr. Rowntree's testimony. This preoccupation has its good and its unfortunate aspects. The UMA bill is submitted as essential due to the unfavorable aspects of present preoccupation on individual separate medical activities to the neglect of integrated over-all planning.

I am utterly and unalterably opposed to the proposed bill, H. R. 5182, since it abolishes the medical service of the VA, makes no special mention of the care for the veteran, or of the continuation of the residency training program.

This bill in no way reduces or changes the Government's medical program for the veteran. The services and preferences due to veterans are established by statute and cannot be and are not changed by this bill.

This bill affects the Administration and the organization which performs the functions established by statute and in no way changes the functions required and established by law. The medical services of the Veterans' Administration, that is, the services provided by the Veterans' Administration, would continue to be administered within the framework of the United Medical Administration.

The residency training program is provided for in separate statute but would also be specifically provided for by amendment to section 3 of this bill detailing the general powers and duties of the Administrator.

Mr. Chairman, in closing I would respectfully like to request you and your committee to permit the Citizens Committee some subsequent date at which we may present further views on this matter.

Specifically, the Citizens Committee would like to present detailed amendments, prepared to perfect H. R. 5182. These would answer some of the appropriate and objective criticisms made of this bill.

Furthermore, we would appreciate an opportunity to discuss before your committee a detailed study we prepared of the hospital beds operated by the Federal Government. This study has been prepared by the Citizens Committee, a private group, at its own expense and is, as well as we can ascertain, the only complete study of its kind in existence. We feel that this study, regardless of its effect upon the legislation under consideration, will be of benefit to all Members of Congress interested in the hospital programs of the Government of the United States. These hearings have clearly shown the lack of and need for such information.

In addition, we would appreciate an opportunity to bring some distinguished members of the task force and of the Citizens Committee to Washington to discuss this matter in public hearings before your committee.

Thank you very much for your consideration.

The CHAIRMAN. Mr. Roosevelt.

Mr. ROOSEVELT. I have no questions.

The CHAIRMAN. Mr. Harvey.

Mr. HARVEY. I think not, Mr. Chairman.

The CHAIRMAN. Mr. Donohue.

Mr. DONOHUE. Do I understand that this Citizens Committee is in favor of the entire Hoover Commission report, that is, in toto?

Mr. MCCORMICK. Yes, sir. We are in favor of the report. Our viewpoint—I would rather keep this part off the record.

Mr. DONOHUE. No. I want it on the record.

Mr. MCCORMICK. Our viewpoint on it, sir, has been that the principles in the Hoover report are correct, and that is why people joined the committee. We have found in every case that it has been necessary to make changes. For example, on plan 7, the President did not submit exactly what the Hoover Commission recommended, but the plan was a good plan and we supported it. We supported many other plans which were not perfect from the viewpoint of the Hoover Commission.

Our viewpoint is very simple. We appraise the thing, and if it is in line with what the Hoover Commission intended, according to our best judgment, we do the best we can to support it, even though it is not real perfect; but, in taking positive action we take positive action on behalf of the specific recommendations of the Hoover Commission. In no case have we gotten the specific recommendation of the Hoover Commission. It has always been considerably changed—and frequently wisely—by Congress.

The CHAIRMAN. Will you explain to this committee how every phase of the Hoover Commission's recommendations could be carried out in any one plan? For instance, we will take this Department of Health, Education, and Security. The Hoover Commission recommended that the Bureau of Indian Affairs be put into that set-up and that certain other things be taken out, but they did recommend that a department be established. The President sought to establish a department. They came in and objected because he would not take out the Indian Affairs Bureau—a thing that can be done and must be done by subsequent act. So, the position that they take seems to

me to be untenable because of the impossibility of doing or obtaining the thing they want.

First, they are in the position where they object to everything or anything because it is not letter for letter in accordance with the recommendations of the Hoover Commisison. An example is the transfer of the loans to small-business authority to the Department of Commerce, where they would be charged with the responsibility of lending money. They objected to it being transferred to Commerce because the majority of the Commission said it should be delegated to the Treasury. It was a split decision of the Commission, however, that decided it.

In other words, anything that is not right close to the line they seem to feel they have the right to object on. They leave no discretion to the Congress or the President, or anybody else with regard to having different ideas and making changes or departures. To me that position is untenable.

I would like to say that the very fact that these witnesses came in and testified against UMA to such an extent that you now would come in and submit amendments in order to cure the cause of their objections, does not mean that they did not appreciate what the present bill set forth in objecting to it. The very fact that you are presenting amendmens shows that their position was rightfully taken, though in speaking of it here you seek to object to the weight of their testimony as not bearing directly on it. However, at the same time, you ask the right to bring in amendments to cure what they object to.

I hope you will bring in those amendments. The committe wants those amendments and the committee will stand ready to hear your testimony, or the testimony of any experts or others you will submit to us, because it is our sincere desire to bring out a good bill.

I was only calling your attention to the fact that though others differed with you it does not mean that they are not honest in their differences and do not see to the core of the matter. If you have to bring in an amendment in order to cure the cause for the objection that was made, then I think the fellow who made the objection made a pretty good witness against the bill as it was then written.

Mr. McCormick. Surely. I am not against reorganization plans. Out of 34, so far we have actually opposed 2, and we have sat "outside" on 1. We supported the other 31. None of them was exactly what the Hoover Commission recommended. Good heavens, we do not think we know everything.

The Chairman. I am trying to get your support for that Department of Welfare.

Mr. Donohue. Mr. Chairman, I do not think that this is a matter of record. What is the Citizens Committee? What is it composed of?

The Chairman. They are a very fine group of men and I appreciate the work they are doing.

Mr. Donohue. But I know that several of them have come out definitely against many of the plans that have been submitted. Will you tell me how it is made up and where it receives its money, and that sort of thing?

Mr. McCormick. First of all, it is made up of a board of directors of approximately 30 leading citizens. They have meetings periodically, at which they consider what has been done and decide what will be done on future measures. The money comes from contri-

butions—and you had better watch your step, sir, or I will give you a contribution card. We ask everyone we can see for money. We send out mailings every other day asking for money. We have succeeded in carrying on on a modest scale.

Mr. ROOSEVELT. What does Mr. Robert Montgomery have to do with the Citizens Committee?

Mr. MCCORMICK. We are sending a caravan all over the country, which stops at every town at noontime and makes speeches to the people on the need for reorganizing the Government. He is chairman of that caravan and crusade which is doing it.

Mr. ROOSEVELT. I think one of the basic fundamentals, though, is having qualified people presenting the points of view. I, for one, was rather shocked that this august group of very prominent citizens should find it necessary to pick out a man who I personally felt had no qualifications to speak about reorganization of the executive branch. In other words, I do not put him on the same level as President Hoover as an expert.

Mr. MCCORMICK. Well, he is a citizen like everybody else, and he has read the reports and is very enthusiastic about them.

Mr. DONOHUE. You mean he has actually read the reports?

Mr. MCCORMICK. I do not know whether he read all of them.

Mr. DONOHUE. Has he read the Speaker's Handbook that is published by this committee?

Mr. MCCORMICK. He has received everything, sir. I cannot say whether he has read it. As far as I know, except for Mr. Hoover and a few others like myself, nobody has read all the reports.

Mr. ROOSEVELT. If you are going in for this kind of salesmanship, I think you ought to put a little "cheesecake" into the act.

Mr. MCCORMICK. Well, Marsha Hunt, the leading actress, another interested citizen has several times cut the red tape from a huge figure of Uncle Sam in various towns.

Mr. HARVEY. I would make this suggestion: That most anything that promises greater citizen interest in their Government is all to the good.

Mr. ROOSEVELT. Very definitely.

Mr. DONOHUE. I would like to request of Mr. McCormick that he furnish us with some of the handbooks that the speakers use when they are going around.

Mr. MCCORMICK. Yes, sir.

The CHAIRMAN. Mr. McCormick, we are certainly glad to have had you with us. Come back often. On these amendments, if you will get them up for us we will give them consideration.

Mr. MCCORMICK. Yes, sir.

The CHAIRMAN. Give us a list of the witnesses who will be available and we will resume the hearing shortly after we return from our July 4 vacation. I do not know yet how long we will be away. If there are no other witnesses and no further questions the meeting will adjourn for future call.

(Whereupon, at 12:10 p. m. the hearing was adjourned sine die.)

UNITED MEDICAL ADMINISTRATION

WEDNESDAY, JULY 12, 1950

House of Representatives,
Committee on Expenditures in
the Executive Departments,
Washington, D. C.

The committee met at 10 a. m., Hon. William L. Dawson (chairman) presiding.

The Chairman. We will resume the hearing on H. R. 5182, a bill to consolidate certain hospital, medical, and public health functions of the Government in a United Medical Administration.

We have with us Hon. Tracy Voorhees, Under Secretary of the Army, and this hearing is convened for his special benefit, because I understand he will not be available to us at a later date.

We are honored, indeed, to have you with us, sir, and at this time we will listen to your testimony.

STATEMENT OF HON. TRACY S. VOORHEES, FORMER UNDER SECRETARY OF THE ARMY

Mr. Voorhees. Thank you very much, sir. But I must immediately disqualify myself as I am not Under Secretary of the Army any longer. I am officially extremely defunct.

The Chairman. Well, you were formerly Under Secretary of the Army.

Mr. Voorhees. At the present time, I am unemployed, thank God, and hope to remain so for a time.

The Chairman. Well, it is nice to be able to look forward to a life of never having to work again. I hope to approach that position in life someday myself.

Mr. Voorhees. Well, I am not in that fortunate financial position either.

Gentlemen, it is a privilege to appear here. I was the chairman of the committee or task force on Federal Medical Services of the Hoover Commission. Before I finished that work, I was appointed as Assistant Secretary, and some time later as Under Secretary, of the Army and was, therefore, in an official position at the time the report came out. I felt that it was inappropriate for me to make any public statements or to take any position in favor of or against anything that was recommended, because there were certain official viewpoints, and I thought I should keep still about it.

Since resigning as Under Secretary of the Army, I have agreed, at Mr. Hoover's personal request, to appear here. I have no personal interest of any kind to serve in this. I also want to make clear that

this is merely my own personal viewpoint and in no way reflects the official view of the Army or any part of the Government.

Mr. HOFFMAN. I understood you to say you appeared at the request of Mr. Hoover.

Mr. VOORHEES. Well, Mr. Hoover personally said that now that I was out of office he felt it would be desirable, if the committee wished it, for me to present certain information about this Federal medical services proposal.

Mr. HOFFMAN. Can you say whether or not your views coincide with Mr. Hoover's views on this matter?

Mr. VOORHEES. I think they coincide with Mr. Hoover's views. I said I was not speaking any official Government view. I want to make clear that I am not attempting to speak for the Army or the Secretary of Defense on this, as they have views of their own.

Mr. HOFFMAN. I think the members of the committee understand that, since the Denfeld incident.

The CHAIRMAN. Will you refresh my memory on the Denfeld incident?

Mr. HOFFMAN. Well, he came down at the committee's request and expressed his views and received a reprimand from the Secretary of the Navy.

The CHAIRMAN. Admiral Denfeld did not testify before this committee.

Mr. HOFFMAN. He testified before the Armed Services Committee, and was demoted and kicked out, and he is now running for Governor on the Republican ticket in Massachusetts.[1]

Pardon me for interrupting you, but I wanted to get that point clear, because someone might have said, in view of your statement that you were expressing only your personal views, that Mr. Hoover did not agree with you, or that the other members of the Commission did not agree with you.

Mr. VOORHEES. No; I think Mr. Hoover does agree with me. It was he who wanted me to testify. I am a free agent, without any Government position, and there is no question of my right, I think, to express my views.

I have no prepared statement. I wish to say that I think I can be useful only in giving some background of essential information concerning this study rather than any detailed information as to the present bill. To the best of my capacity, I shall try to answer any questions which you may have.

I have come down here from New Hampshire for the purpose of testifying before you. Whatever qualifications, if any, I have in this field, gentlemen, arise from the following experience. Although in a previous incarnation before Pearl Harbor I thought I was a lawyer, I had been interested in medical matters for a long time as vice president and later as president of a large teaching hospital in Brooklyn, which is my home, later in organizing the first public blood donation service for plasma in the country in the summer of 1940, and then for 3½ years I served, at Under Secretary Patterson's request, with the Surgeon General, and during a part of that time I was adviser to the Surgeon General of the Army on organi-

[1] Captain Crommelin exercised his right of free speech and he was kicked out of the Navy and is now running for Senator on the Democratic ticket in Alabama.

zation. I then served overseas in various theaters in connection with medical supply problems. My work was in connection with organization, not professional medical work, of which, naturally, I know nothing, as I am not a doctor.

Then, following the surrender of the Japanese, at a time when we had about 250,000 patients in our Army hospitals, Secretary Patterson asked me to come over to his office and act as an assistant of his in advising him as to Medical Department problems which he had to meet. The tremendous obligation to care for so many wounded, coupled with the natural desire of the doctors to get back to their civilian practices, created, of course, a very great problem.

I continued in that work for approximately 7 or 8 months, devoting most of my time to it, until I thought the problems had pretty largely cleared up. Later, for many months in 1948, I directed or supervised the study of the task force of the Hoover Commission in connection with the Federal Medical Services. In that we got together a team which I believe was a very strong one. It included Dr. (previously Maj. Gen.) Paul R. Hawley, who was the one man in the country who combined a vast experience in military medicine because of his service in the Regular Army for many years, culminating in his post as Chief Surgeon of the European theater, which had the greatest casualty problem, of course, and then later his distinguished service as Medical Director of the Veterans' Administration.

Until that time, I think it is fair to say that the Veterans' Administration had furnished very unsatisfacory medical care. The greatest single improvement that has ever been made in medical services on a large scale in peacetime was made by the Veterans' Administration since the war. It is one of the very great things that I believe has been done in medical care. Two men were principally responsible for it—General Hawley, who set it up, and later Dr. Paul Magnuson, who succeeded General Hawley and who had assisted General Hawley. Dr. Hawley participated very actively in our study. We also, of course, consulted with Dr. Magnuson, and the recommendations which we made were in considerable part based upon Dr. Hawley's recommendations were fully supported by Dr. Magnuson.

Then we had half a dozen or so of the leading doctors of the country who had served in the Armed Forces during the war. I mean civilian doctors who had been brought into the service during World War II and therefore had had a very large taste of military medicine as well as experience in posts of outstanding position in civilian medicine. There was Dr. Churchill, professor of surgery at Harvard, who has been the president of the the American Surgical Society, I believe the name is, the elite surgical group of the country; Dr. Morgan, who I believe appeared here, who was president of the American College of Physicians and who was a professor of medicine at Vanderbilt and was the chief medical consultant for the Surgeon General during the war. I should have said Dr. Churchill was the Chief Surgeon of the Mediterranean theater and was responsible for a greater improvement in surgical procedures in wartime than any other one man. He served as vice chairman of our task force.

There were various other distinguished men, including Dr. Will Menninger, the leading psychiatrist, and then Dr. Richards in research, who had been the head of medical research in Dr. Vannevar

Bush's Office of Scientific Research and Development during the war, and Dr. Leavell, who was professor of public health at Harvard. Those last two men were added to the committee because we felt much greater emphasis should be placed upon research and upon public health—that is, the prevention of disease rather than just curing people who are ill.

An illustration of that is the fact that we had some projections prepared, I believe by the Metropolitan Life Insurance Co., for us, showing that, if matters went on as they were then and we had no new war which would, of course, make them worse, we might have by 1975 something like 250,000 veterans in hospitals about three-quarters of whom would be mental cases.

Let me say we also had two distinguished men who were presidents of civilian hospitals and two of the outstanding administrators of hospitals in the country.

Then we subdivided our work and got in experts in different fields to make the detailed studies from which our report was consolidated.

In doing this work, Mr. Hoover gave us one very specific instruction, and it was this: He said he wished us to recommend the organization and the steps which would produce the most efficient and the best medical care; that we were not to compromise on the basis of whether it would be easy to get through the legislation for it. There were various compromises in this field that would have been very much easier to get through, much more palatable to many who are concerned with it, and those could have been proposed as alternative measures, but Mr. Hoover said he wanted the best. And after we went into this, it was perfectly apparent that a consolidation of the Federal medical services would produce the best care, in our judgment, and the best research and the best preventive medicine.

Now, whether that consolidation should be as a separate Federal medical service or agency, not a part of one of the departments, or ether it should be a part of a Department of Welfare, if such a department is created, is an open matter on which our committee at least felt that either would be successful. Our preference for the best effectiveness would be for a separate Federal medical service, but we felt it could also work effectively as part of a Department of Welfare or a Department of Health, Education, and Security. Such a department has been called, I believe, by both names.

There are great advantages both ways—advantages in incorporating health services into a department because of the intimate relationship which must exist between such services and the other welfare services, and on the other hand advantages in a separate Federal medical service or not being part of a department and so being in perhaps a better position to represent the medical care needs of the different agencies of the Government which have to have such medical care. Among these, the veterans are by far the biggest and most important, unless we have another war, and the domestic hospitalization of the Armed Forces, which, next to the veterans, in peacetime would be the biggest.

Now, these are all matters of opinion. They are matters on which reasonable men may differ and did differ, and certainly no one should be dogmatic about it. Our committee's recommendations, which are in general accepted by the Commission, are not necessarily the only means. I do wish to say, however, that there was complete and

absolute objectivity on the part of the people who made this study over many months. No one had any ax to grind; no one had any special interest to serve. We were concerned only with these things—first, how to get ahead with research, if possible, which would prevent some of those diseases both for the Federal patients and all the others, and that is the most important thing above everything. Next, how to apply as effectively as possible the preventive medicine or so-called public health procedures which are known, because we could take tremendous steps forward for the health of our veterans and for the health of our population with the medical knowledge we have today and which are not being taken at the present time because of lack of organization. And finally to give the very best medical care possible to patients for whom the Federal Government is responsible.

I think there has been a great deal of misunderstanding about this report, and I would like to try to correct a little of it. We did not consider that it was in any way our function, but that it was the function of Congress, to determine what beneficiaries should receive Federal medical care; that is, whether the non-service-connected veterans should get the care or whether they should not, for example, they being the largest class, was not a matter for us to determine. What we were trying to determine was how they could get the best care if the Federal Government decided to give it to them.

Now I am going to digress, if I may, to the situation which has developed since the time we made our report. Our report was made in an atmosphere bordering between peace and more or less localized cold war. It was not pointed primarily toward a wartime situation. Since that time, in the period of the last year and a half to 2 years, great changes have occurred. I have often been asked whether there were not subsequent changes which would alter the recommendations in our report. It is my best belief that the changes which have occurred have reinforced the necessity for the reforms proposed in the report.

Gentlemen, we all know that peace has now departed and we live in a climate of as yet a localized hot war and a global cold war and increasing threats of a global shooting war. We live with the Russian atom appearing over the horizon perhaps, ready sometime from now—perhaps several years—to take a closer look at our cities. Speaking as a citizen—and in these things I am talking about now, since they occurred since the report, I do not speak for my colleagues but only for myself—reforms that were desirable in peace for the economy both of doctors and Federal appropriations, now I believe become absolutely imperative for the safety of the millions of our citizens in the now ever possible war situation before us and in the certainty that there is today no insured immunity of our great cities if an atomic attack comes sometime within the next several years. If this does come, it is logical to assume it will be a big one planned to knock out our known industrial and retaliatory potential. The only thing we do know is that that industrial potential of the United States, which is its greatest war potential, is the thing which Stalin fears above everything else.

He said repeatedly during the war—and I am sure I am correct in this—that Germany could never win because of the tremendous industrial potential of the United States. I am sure he has not forgotten

that. If we can preserve all of that big industrial potential, we never need fear for our own power. All we need, I believe, is faith in ourselves. I am not so much afraid of the Russians; I have only the question as to whether we are ready to use our potential and can maintain our potential.

Now, this atomic attack on our cities we pray may never come. I think there is a fair chance that it will not come. But if it does come, I believe we must have the defenses ready so that it will not achieve the result which Stalin has in mind. Certainly as a minimum measure of safety for the millions, we must be prepared for some atom bombs getting through and hitting our cities. If they do, there are going to be tremendous casualties and a tremendous medical problem.

In this matter, the Federal medical services have obviously an important part, because such an attack would not be just a local matter. It cannot be viewed as just a local civilian defense proposition in any one city or, indeed, in any one State; it will be a national matter. There is no motive for Stalin or the Kremlin to make any such attack unless it would have a chance to knock out a very substantial number of our industrial cities and our Atlantic ports. If we get it, therefore, it is going to be one which is at least attempted on a broad scale.

Now, that means immediately a Federal problem, as I see it, in the medical field, because it is going to be far bigger than any State or any city. Most of our hospitals, of course, are purely local institutions. Other than Federal hospitals, almost all of them are. Most of them, in fact, are simply separate individual institutions, and we have in the larger cities groups of institutions—of city hospitals, for example—and for chronic cases, such as mental and tuberculosis cases, we have various State institutions.

In any large-scale atomic attack, clearly those local institutions are not organized in a way to cope with the problem, but the Federal Government's great, Nation-wide hospital system could cope with it or certainly would be the best equipped to cope with it, provided—and there are two great provisos—first, that they are under a unified direction and, second, that they have a firm arrangement with local institutions—that is, with community hospitals throughout the country—for the instant use of the latter's hospital beds to take care of Federal patients on a reimbursable basis.

We must remember that these hospital beds that we have are occupied by patients who are sick in varying degrees, and we are going to have to empty those hospitals to a very considerable extent to make room for the casualties that urgently need care. That requires instance action and planning in advance.

The CHAIRMAN. Would you advocate a new hospital-building program?

Mr. VOORHEES. No, sir. I will make one qualification of that, but let me first say I do not believe so, becasue for the Federal Government we have hospitals that are adequate for the patients we are taking care of at the present time and we have hospitals that are more than adequate, including those under construction, for all of the competent doctors we are able to get in the Federal medical service.

I am one of those people—and let me say I am a veteran myself—who is not interested in getting into a hospital bed if I do have to

get medical care. It is not getting into the bed that I am interested in but getting out of the bed and getting out vertical and walking——

Mr. HOFFMAN. Since the chairman has interrupted you, if it won't interfere with your thought, let me say that seldom a week goes by that Mrs. Rogers of the Veterans Committee does not come to me over on the floor and insist that the Government is throwing veterans out of their beds. What is there to that? I do not know a thing about it.

Mr. VOORHEES. Will you permit me to answer that later?

Mr. HOFFMAN. You will take it up later?

Mr. VOORHEES. If you will permit me, I will take it up later. I will certainly cover that as best I can.

Now, the nearest comparable hospitalization experience that we have had to the problem which we would have if there were a large-scale atomic attack on our cities is that which the Army had in the later stages of the last war. The Army then had a system of beds—I am testifying from memory; so the figures are approximations only—the Army had hospital beds in this country of well over 200,000 beds. That, of course, is very considerably greater than the entire Federal hospital system at the present time. The Army received in the later months of the war, for several months at a time, more than 50,000 casualties a month from overseas who had to have hospital care. An illustration of the size of the hospital beds needed for 50,000 casualties is that that is some 16 times as big as Bellevue Hospital in New York, which we always think of as a tremendous hospital. That number of patients were taken care of a month, and they were given excellent care. This was possible only because there was one hospital system which was taking care of them and because that made possible, in turn, a central regulating unit which, as soon as patients arrived in this country, assigned the patients to the hospitals which had free beds—because they had daily reports of such beds—and which were staffed to give the patients the specialized care they needed and which, consistent with those things, were as near to their homes as possible. Had that not been done, we could not have given a high quality of care to those patients.

Now, such a regulating system is urgently needed to meet the present atomic threat to the public safety, at least in my judgment. It must, to be effective, have full control of all Federal hospital beds. It must have arrangements in existence to put patients, at an hour's notice, not only into community or city hospital beds on a reimbursable basis, because otherwise it could not do it, but also it must have arrangements and authority to make room for these patients—that is, to take some of the Federal patients and the patients in those community hospitals out of hose beds they are in instantly—that is, the patients who are there for elective procedures which could be postponed and the patients who are not so ill; patients who might be able to be taken care of somewhere else, and to move them out without protracted negotiations and take care of them for the time being outside of hospitals so that we could use the limited hospital beds we have for the acute casualties.

There are two great limiting factors in medical care for serious cases. The first is the absolute limit on the number of doctors available and, within that limit, the number of specialists, specialists being

shorter in over-all supply than doctors. Second and related to it is the limiting factor of the number of adequately staffed hospital beds—that is, beds staffed not only with doctors but with nurses and all of the other complicated services which are essential to modern medicine. The supply of neither of those can be greatly increased quickly, however desperate the emergency; so we will have to use what we have.

I think the biggest thing is that we must be prepared to use the ones which we have to the best advantage so that the patients will get no only in the hands of a doctor, not only in a bed, but in the hands of doctors qualified to give the best specialized care for the particular type of injury; and there will be all kinds of illnesses and injuries which such patients have.

The Army in the war ran out of specialists. It met the problem by subspecializing its hospitals. Take, for example, plastic surgery. There were only a few specialists in plastic surgery. I could perhaps give a better illustration from amputation cases, which I was very much interested in. I think there were at one time half a dozen hospitals which had been subspecialized to deal with amputation cases. Similarly there were a few to deal principally with plastic surgery cases. That was because there were only a few doctors in the whole country best qualified to deal with those cases and to give them the care they needed. So we brought the patients to the doctors and then had younger doctors to help them, so that the senior doctors who had the greatest knowledge could supervise the care of many patients.

It is marvelous what you can do with specialists if you give them the support of younger doctors. The bulk of the work is done by the younger doctors or through the younger doctors but under the supervision of the top man. It is in this way that you can maintain the highest quality of care.

I am tempted to digress here because this is a subject in which I am tremendously interested and which I think you would be interested in studying.

The CHAIRMAN. The pay for the Medical Administration would be set out in the bill?

Mr. VOORHEES. Of course. We have in this country so much of the best medical care that there is in the world that there is not even any comparison, and the progress of our medical care—and I speak as a lawyer, speaking of another profession, not mine—has been so great in the last 15 to 20 years that we have made more progress in the care of the sick than has been made in the whole history of man prior to that time.

Let me give a couple of illustrations. In the past 50 years, we have added almost 40 percent to the length of life in America. What greater gift to man can there possibly be than the gift of more life?

Let me give another illustration: Specialist care in cancer cases. I use that disease as one in which everyone is interested, one of the most discouraging—perhaps the most discouraging—disease, one for which no real solution has been found. If you can diagnose cancer in the early stages and you place the patient under the average medical care in this country, the best in the world, only 30 percent will survive—these are figures of a year and a half ago and are embodied in our report. That is, be cured—and in cancer what they call cured is, 5 years without evidence of a return. But in our best cancer clinics, granted a similar early diagnosis, two-thirds survive and are cured—

practically 200,000 out of a little over 300,000 cancer cases a year. The difference between the optimum specialist care, which I have been talking about and which we have been trying in this report to provide, and the average care is that under the former, twice as many are cured. That is the thing which I believe we must aim for for all of our citizens, and particularly, since it is our responsibility in the Federal Government, for the veterans and the members of our Armed Forces who are wounded or are suffering from conditions resulting from war or conditions which do not result from war but where they need care and are granted care.

Now, the report which we made to the Hoover Commission and which was in general approved by the Commission proposed a system under which it would be possible to have the maximum effectiveness and speed to mobilize the Federal medical resources and the community resources to meet whatever is before us. It is my personal opinion that that report ought to be dusted off now and looked at not only from the needs in mind at that time, the economy of doctors and money and better professional care in peace of Federal patients, but also urgently as an instrument for the protection of our citizens if war comes.

Now, gentlemen, in the last war the Army went out and got its doctors. The Air Force was then part of the Army. The Navy got their doctors separately. There was some coordination of it through a voluntary committee in the medical profession, but the Army and Navy separately determined their requirements for doctors, and between them they took roughly a third of all of the doctors in the country. They took them to take care of something less than, as I recall the figures, 5,000,000 of our young men who had been selected, among other reasons, for their good health. Now, of course, they got illnesses overseas due to war conditions—some of them—and that was particularly true in the Pacific, and a great many of them were wounded, and therefore they needed more doctors per individual, of course, than the civilians. But just look at this—we left only two-thirds of the doctors to take care of about 135,000,000 of our citizens, and these citizens are entitled to care even if they are not in the Armed Forces and are not veterans.

Now, there was a tremendous waste of the time of those military doctors. They were mobilized before it was necessary. Great hospitals were staffed here with very few patients in them for a long period. You cannot increase the supply of doctors in times of emergency, and in another war you would have a very different situation. In the past war we happened to have a wonderful record of public health. There were no epidemics and, of course, nothing in the way of attacks on our country which caused any civilian casualties. But in any war with which we may be confronted and which we must plan for—and let me say I am not prophesying any war at all; I think we can avert it, but I think the best way to avert it is to plan for it and to be sure we are ready—our public is not going to be satisfied to have two-thirds of the doctors to take care of over 150,000,000 people, when the people are subject to the risk of atomic attack at any hour. We shall have to devise a system which will make the maximum and most flexible use of our doctors, and particularly of our specialists, so that they can give the care which is necessary to the members of our fighting forces, to our veterans, and to the public.

I do not think anything less than that can be tolerated as a matter of sound organization, because, frankly, it would mean death when it could mean life, and it would mean the crippling of a great many people and permanent invalidism where that is not necessary.

Now, if you threw away every single reason for efficiency and economy in peacetime and put them in a scrap basket and just consider a logical preparation in this field for the danger which confronts us of a war, I believe you would do the two main things which we tried to recommend in this report, namely, a unification of the Federal hospital services in this country and arrangements by which the Federal patients can be taken care of in community hospitals on a reimbursable basis.

That brings me to the question which was raised about veterans' medical care, and I want to make this very clear: There was nothing in our report which recommended any poorer care or any less care for veterans. The report was designed to assure them the best of care and to assure that care to whatever veterans the Federal Government decided, through the Congress, it would care for.

Now let us take a look at this veterans' situation by and large to try to answer the question which was raised. We have now a little over 100,000 beds for veterans. We have veterans with service-connected disabilities running somewhere in the neighborhood of 35,000. A certain number of the latter—quite a substantial number, I believe; I have not the exact figure—are taken care of outside of Federal hospitals. The reason for that is that we have assumed, as we should, an absolute obligation to take care of the service-connected disabilities, and therefore there is a legal right of the Veterans' Administration to put those cases in community hospitals or other places for care upon a reimbursable basis. In other words, they do not all have to be taken care of in Federal hospitals, because the Federal Government has assumed a clear obligation to care for them. But these service-connected cases are only roughly—my figures may be a few months out of date, but they will give the picture—35,000 out of something over 100,000 veteran patients who are receiving Federal care.

Now, the care for the non-service-connected cases grew up gradually under a fiction; that is, that they would be entitled to care only if there was a bed available and if the patient indicated that his own finances were such that he was not able to provide for his care. The result of that has been that these veterans did not have a clear right to a bed. In other words, beds were not provided especially for the non-service-connected cases, although clearly it was the intention of the Congress that many of them should be taken care of, as is shown by the fact that you provided and have under construction some one hundred and thirty thousand-odd beds for veterans' care as against some 35,000 service-connected cases. In other words, you have a hospital system at least three times as large as the service-connected cases; so it is perfectly apparent that it was the intention to take care of a large number of non-service-connected cases.

I want to say I support that, although I hope I am not going to be a non-service-connected case in one of the hospitals and I am not speaking from any personal interest.

It was the position of the committee and of the Hoover Commission that this should not be left to chance; that the way to plan the thing was to determine clearly the patients who are entitled to Federal

medical care and then give them the right to the care; not when and if a bed is available, but either to give them the care or not give them the care.

Now, there are great advantages in doing that. Let me analyze them: Of, say, 75,000 non-service-connected cases as a rough figure—it is something like that in our veterans' hospitals, and all of my figures must be taken with a grain of salt, because I am testifying from memory, and frankly I am a few months out of date, but none of them are off sufficiently to affect the principle of what I am talking about—of those non-service-connected cases, well over two-thirds are chronic cases. Now, gentlemen, something like 98 percent of the chronic cases are either medical indigents at the time they become ill or are made medical indigents by the duration of their disease. In other words, they need Federal care. All of them do. There is not any use for any pauper's oath for that group. We ought to take care of them.

Another thing is that there are not enough community hospitals; there are not enough State institutions or city institutions to take care of those people. Those institutions are overflowing with mental cases and tuberculosis cases, and there is not any use in trying to talk to the States or the cities about taking care of them. In my judgment, those cases ought to be taken care of by the Federal Government—that is, the veterans who are chronic cases—and I do not think you need to bother with any pauper's oath. If there is not a bed available, we ought to make a bed available. Now, actually we are doing it and we might just as well give them the clear right.

You come now to the acute cases of non-service-connected disability which represents a relatively minor part of this situation, and that is a matter for the Congress and nobody else to determine. I mean the legislative process should determine whether we will give that care in acute cases of non-service-connected disability only to those who cannot afford care in their communities, or have all of them who need the care get it irrespective of their financial condition. Actually, we are doing substantially the latter at the present time, except that we have not planned to do it. It is because of that overflow of nonservice-connected cases, and because of the rule that they will only be cared for if a bed is available that you have Mrs. Rogers' position that veterans are waiting for beds and not able to get them.

Mr. HOFFMAN. She says that they have been thrown out of hospitals. Where have you been throwing them out, if they have been thrown out? I do not believe it, but perhaps she is right.

Mr. VOORHEES. I think that you would have to get Dr. Magnuson of the Veterans' Administration to give authoritative testimony on that. What I think that means is this: There is a great pressure from the waiting lists of veterans who need care for acute conditions; for example, elective appendix operations and elective hernia operations, and so forth. They are waiting to come in. Therefore, undoubtedly, cases are taken out of the hospitals at an earlier time than they might otherwise be, in order to make room for the new patients who are pressing to come in. That is done in the civilian hospitals at all times. You know the average stay for a case in a civilian hospital has been very, very much cut down because of that pressure, and also because of economic pressure. I am sure that the very able medical directio-

of the Veterans' Administration is making the best use of the hospital beds it has.

I want to say that if you determine that the acute cases only get care if they cannot afford to pay for it, that is one thing, but if you determine they will get care whether or not they can afford it, that is substance what we are doing now. It would be very much better if you gave them the clear-cut right to the care in one form or another because of the fact that would then make it possible for the Veterans' Administration to do in the nonservice-connected cases what they are doing in the service-connected cases and contract the care out to non-Federal hospitals to the extent that it is possible and wise to do so.

Mr. HOFFMAN. What you are saying is this, is it: If a man is a veteran, or if a man was in the service and he has a serious case of poison ivy or sumac, or appendicitis, the Federal Government is under obligation, regardless of his financial situation, to take him into a hospital and furnish him a doctor?

Mr. VOORHEES. I expressly refrained from saying that. I said at the present time we are, insofar as beds are available, taking care of all nonservice-connected cases—practically.

Mr. HOFFMAN. I also understood you to say there were not enough beds or doctors available.

Mr. VOORHEES. There is a waiting list as it is now run.

Mr. HOFFMAN. If a fellow has acute appendicitis, he cannot wait very long.

Mr. VOORHEES. They take care of the emergency cases immediately, and they postpone the elective cases.

I am convinced with the present number of Federal hospital beds that you have in the United States, and with the present staff, and if it were managed on a unified basis, and if you kept the patients in only the length of time that it is ncessary for them to have hospital care, you could take care of them.

Mr. HOFFMAN. My contention is if the Government is to assume this obligation of taking care of every acute case just simply because a man was inducted into the service, then there should be some form of legislation so we would know now just what we are doing.

Mr. VOORHEES. That is exactly what I said. I expressly refrained from making any recommendation, and so did our committee, one way or the other on that. All we said, as I stated, was, "Let us look at the facts of life." In the chronic cases we are doing it now. Of the chronic cases 98 percent are medically indigent, anyway, and you have to take care of them.

Regarding the acute cases, there are a good many who could provide for their own care, and it is a matter for the Congress to decide what should be done, but it would be very much better for the veterans and very much better, in my opinion, for the Government to give them a clear right one way or the other than to leave a bunch of them just waiting until a bed is available.

Now, I would like to stress the very great advantage of a unified medical service in connection with medical research.

Giving figures from memory again, of the hundreds of millions a year that the Federal Government is paying for medical services, only about 3 or 4 percent is spent on research. Only another 10 or 11 percent, as I recall, is spent on all aspects of preventive medicine and public health.

Now, we have a great medical obligation already which is costing the Federal Government hundreds of millions a year, and it is a just obligation, but it is to the interest of these people to be well, not ill. If we can keep them well and not have them in the hospitals, that is better for the Federal Government and very much better for the veterans who will not then be patients.

The unbelievable strides in research are so great that the Federal Government simply for its own financial interest could receive dividends—and I cannot calculate how big they would be, but they would be large—if the optimum were done in research in these great diseases; and also if the optimum measures were used in preventive medicine and public health the same would be true.

Let me give you an illustration in tuberculosis. There is a disease which has in the country been reduced, as I recall, by two-thirds or more in half a century. Perhaps the reduction has been larger than that, but it has been a tremendous reduction. The reduction has been, primarily, not because of the new treatment with the antibiotics, although that has been the cause of very recent great strides, but by diagnosing the cases through X-rays and by putting those patients in hospitals where they do not infect the other members of their families. That isolation has been the big thing that has made the advancement possible.

Now, there is very respectable opinion—though there is some dissent—that we have it within our power to eliminate tuberculosis in 10 years as a disease. We are not doing it.

Mr. HOFFMAN. I think we will all agree with you that prevention is a whole lot better than cure, but what some of us are interested in is what is the best method to get at all of these things and what form of legislation we should adopt to accomplish this.

Mr. BONNER. Is not that the purpose of this bill?

Mr. HOFFMAN. I thought so.

Mr. BONNER. It is your bill.

Mr. HOFFMAN. I think that you do not have to argue with the committee that an ounce of preventive is worth a pound of cure.

Mr. BONNER. I thought that you had it in here and that this would be a cure-all.

Mr. HOFFMAN. I thought so, too, and I though he could tell us why this particular bill was as good as, or better than, or worse than——

Mr. BONNER. Who is criticizing the bill?

The CHAIRMAN. The veterans.

Mr. HOFFMAN. Have you not heard from the veterans?

Mr. BONNER. Is this the bill we had up some time ago when the Veterans' Administration was here?

Mr. HOFFMAN. The Veterans' Administration came in and said, "Why pick on us?"

Mr. BONNER. I thought this was something new.

The CHAIRMAN. Then there were the doctors.

Mr. HOFFMAN. They say that this bill is going to take the hide right off the veterans.

Mr. VOORHEES. You asked me what could be done?

Mr. HOFFMAN. The veterans come into my office and say, "This means you are misusing the veterans. You want to send them out into the gutter to die." That is not so. How does this bill do that?

Mr. VOORHEES. You were asking about research and prevention?

Let me say that research and prevention measures merge into each other to such an extent that you can hardly separate them. The greatest thing in research is, of course, the clinical material on which to conduct research, and to have that clinical material meet up with doctors who have the capacity to make the studies of those cases.

Let me use cancer as an illustration because of the interest in the disease:

Speaking from memory, the Veterans' Administration about a year and a half ago had something like 15,000 cancer cases in its hospitals. Now, do not hold me exactly to that figure, but it was a large number. That number represented the greatest body of clinical material available for research in cancer that was available anywhere under management so that you could control it, watch the cases, seeing the subsequent effects, and so forth.

It is of tremendous value to have your research connected with your hospital system.

While the Veterans' Administration does splendid work in research, and also the Army, the Navy, the Air Force—and I have only commendation for all of them, and there are some other services of the Federal Government that doubtless do well—the Public Health Service has the major responsibility for research and the Veterans' Administration has the major clinical material.

If you want to start a medical school you do not start a medical school by setting up a number of buildings and teaching. You go first to a big hospital, or to several, where you have the clinical material for them to work on. The same thing applies to research. You have to have the clinical material.

Now, the unification of medical services would join the research with the clinical doctors who are giving the care to the patients who form this mass of clinical material. It would join all this with your laboratory research into the strongest team possible. That will be the best way to get on with prevention of disease.

The progress in dealing with the great diseases is so utterly fantastic that we hardly grasp the progress that is being made.

The CHAIRMAN. Do you mean to say that the progress is in the disease itself taking hold of the American public, or the progress is in research to prevent these diseases?

Mr. VOORHEES. The progress is in research in preventing as well as in treating cases in their early stages and getting rid of them entirely.

The CHAIRMAN. Is not that being done under our Public Health Service through grants-in-aid work, in close harmony with the States and private institutions to further these studies in research? I know at Howard University we have cancer research set up. You have it in every big school in the country maintained by grants-in-aid from our Government through our Public Health Service. That is right, is it not?

Mr. VOORHEES. Yes.

The CHAIRMAN. And they have done a good job under the present set-up—the best in the world, have they not?

Mr. VOORHEES. It is the best in the world. I would like to say that I am very much interested in the work at Howard University because its professor of surgery was a very warm friend of mine, Dr. Charles Drew. He was unfortunately killed here several months ago. He

was educated by the Rockefeller Foundation to be an outstanding teacher of surgery. He and I served together in the original public blood-donation project in 1940. He did a tremendous job.

Now, I would like to say that I have the very greatest respect for what is being done through those grants-in-aid; through our medical schools of which Howard University is a very good one, an excellent one, and what is being done through our Public Health Service.

The people running the Public Health Service are devoted men, men with very great ability, but all I am saying is that it would be of tremendous advantage, I believe, if you could marry up the clinical material with the responsibility for research.

The CHAIRMAN. Just as they are aiding the various hospitals that are city-owned, State-owned, and privately owned in research, are they not also doing the same thing in connection with the veterans' hospitals all over? Is there not a research clinic where we have these 15,000 cancer cases?

Mr. VOORHEES. They are doing research on those cases, but there is quite a little difference between having one agency, the Public Health Service, primarily, responsible for research and another agency having the patients. They can select a few cases and bring them to the Public Health Service hospitals, as they are going to do that at their big new institution at Bethesda.

I think a fine job is being done, but what I am urging is what is the best system? How do we go forward with it to get the best? There is a very great chance of finding a means of reducing cancer and other diseases. The progress is tremendous. But what I am arguing for and urging here is the best organization to do it, and then centering the money so that you do the research on the optimum basis. It should be limited only by the number of people who are able to do research effectively, whether they are in the Federal Government, or are financed by grants-in-aid, or by contracts with our schools. It should not be limited by money. I believe that is not only good for our citizens, but in the long run very good for our Federal Government because of the fact that it will diminish the financial load on the Federal Government.

I would like to speak about the Army, the Navy, and the Air Force hospitals. It is clear that the primary function of the Armed Forces medical services is the care in wartime, and after war, of the members of the armed services. When the men are permanently incapacitated for any cause, they should take care of them by the Veterans' Administration, which is good policy.

Now, I should not unduly limit the responsibility of the armed services Medical Department. There is the care during peacetime, which is a factor, and there are the tests and methods for trying to keep healthy men in the armed services. There is the prevention of disease and research in military medicine.

Beginning with the time of Walter Reed himself, very great strides have been made in research, and I think that the quality of the medical departments of the armed services needs no defense.

But hospitalization in the continental United States, particularly in military general hospitals where the serious cases go, is not really directly related to the effectiveness of the military service—maybe indirectly but not directly. That is because most of the cases serious

enough to go to a general hospital, a large percentage, never get back to active duty. The thing to be done regarding the serious cases is to have them get the best care possible and care somewhere near home.

Let me say the armed services have to run hospitals overseas and they have to run what we call the attached medical, that is, the medical units directly attached to the troops. Their medical service, for example, to our boys in Korea obviously will have to be given by the armed services. When I talk about a unified medical, I mean only in the hospitalization in the continental United States. And there is an exception there for military-station hospitals at post where other hospitalization nearby is not available.

There is another factor that I think should be given very great consideration.

Due to the separation of the military hospitals from the veterans' hospitals and the separation of all from the Public Service hospitals, and the fact that some two-thirds of the veterans because of existing legislation can be taken care of only in Federal hospitals, whereas many ought to be taken care of by contract with the community hospitals in order to utilize both our doctors and hospital systems as effectively as possible——

Mr. HOFFMAN. Just why did your committee recommend the consolidation of these hospitals?

Mr. VOORHEES. We recommended that for two reasons. In the first place, to make the best use of the doctors we have; secondly, to get the patients to the specialists.

Mr. HOFFMAN. I understood you to say before the primary object was to get better care—the best care possible.

Mr. VOORHEES. That is right.

Mr. HOFFMAN. For all the people who are going to be treated. Why do you think they will get better care if the services are consolidated under one agency?

Mr. VOORHEES. That is the essence of the thing. You asked me what our committee recommended, and we were talking then about a peacetime condition.

Mr. HOFFMAN. I agree with you that the present situation has only lent force to your present recommendation.

Mr. VOORHEES. It is accentuated in war, but I am speaking now only of peacetime. Quality care is the objective. Quality care means specialist care.

Mr. VOORHEES. You have a shortage of doctors, and within the over-all shortage of doctors you have a greater shortage of highly qualified specialists. Let me say that we have partially qualified specialists, young fellows who have had this and that course, who are very good and who attached to and working with an outstanding man with a national reputation can do better work than they can do alone.

Mr. HOFFMAN. What you are trying to say is you have only a limited number of specialists, or a limited number of qualified people to take care of these cases, and you want them under one control where they can be made available?

Mr. VOORHEES. Where you can get the patient to the best specialist at a point nearest to his home. The point nearest to his home is a very significant factor because of the morale of the patient. After all, these people are human and do not want to go to some distant point. Their morale goes down and they do not get well as quickly. But also

there is the fact that if these patients are nearer home you can effect tremendous savings in the number of hospital beds. I mean by use of the voluntary hospitals, the charitable hospitals. As the beds got shorter and the doctors got shorter in number during the war, such hospitals met that situation by getting the patients out of the hospital much quicker.

For example, a maternity case that would be in from 10 to 14 days was limited to an average time of about 5 days. An appendix case was reduced to 7 or 8 days, or something like that.

I mention cases like that because you can get a better average from them than from the various complicated cases. If you take an uncomplicated procedure you get a better estimate of average hospital time required.

In the veterans' hospitals the time that the patients were in the hospitals was something like two and a half times, well over twice, the time that the patients are in the voluntary hospitals for the same operation. That is not necessarily the fault of the administration, but is due to the fact that the patients are further away from home, and although they do not require hospital care they do require the attention, let us say, daily, or every other day, of a doctor. Therefore, they stay in the hospital. That is also very true of the Army and Navy hospitals.

If you are in a position to take care of the patients under a unified system proposed, you will have a great many of these cases taken care of nearer to their homes, which would be much more satisfactory to them and which would get them out of the hospitals more quickly. In other words, you would make much better use of the doctors you have and of the hospital beds you have. Those are the principal things. I will be glad to answer any questions.

Mr. KARSTEN. I was very much interested in your testimony, particularly your conclusions. It is my conclusion that there are not enough doctors. Is that the basic reason for this difficulty?

Mr. VOORHEES. I would not agree with that.

Mr. KARSTEN. You have two points, to get the best use out of the available doctors, and you did say there was a shortage, and secondly, arrange for specialists to give treatment to the patients.

Mr. VOORHEES. That is right. May I try to bring that a little more sharply into focus. Overall in the country I have no doubt we have enough doctors to take care of our patients if we could make full use of them all. In the several Federal medical services there is a very definite shortage of doctors because doctors can make a lot more money, by and large, in civilian life, than they can working for the government.

Mr. KARSTEN. Did you make any recommendations that would make it attractive for doctors to enter government service?

Mr. VOORHEES. What we did was to do it the other way. We proposed a definition of the veterans' rights so that you could take the non-service-connected veteran to a doctor on a reimbursable basis and put many of those patients in the community hospitals so that hospitals not part of the Federal service could take care of them. Therefore, you in effect extend the capacity of your Federal doctors.

Perhaps one of the greatest things that the veterans' medical service has done is that instead of trying to take care of all those veterans by doctors who are hired full time for the Federal medical services, they

have built hospitals, for the most difficult cases, next to medical schools, and are permitting the employment on a part-time basis of doctors. They have been able to get very excellent specialists, but they have gotten them on a part-time basis, 3 days a week, or three mornings a week. They come into the veterans' hospitals and take care of their cases and at the same time devote a part of their time to their own practice and to teaching. Nobody needs to change that. That has made a very remarkable improvement. But that is not alone sufficient, in my judgment.

Mr. KARSTEN. You are creating the impression that is the general practice and that is not true. If you have a brain surgery case the best expert in the area will be consulted and brought in on the case. Provision is made for that in the law. However, the ordinary case of tonsillectomy or appendectomy is taken care of in a veterans' hospital now, irrespective of whether the case is service connected or nonservice connected. Where you have the complicated cases it is the desire of the doctors in the Veterans' Administration to render the best possible medical service. Specialists are consulted when the cases require expert medical attention. That is not the general practice in the run-of-the-mill cases in the veterans' hospitals.

Mr. VOORHEES. You are correct. You are going into another field that I did not mention. You are going into the consultant field. They have as consultants many of the outstanding men who devote only a relatively small amount of time to the Veterans' Administration. The same thing applies to the Army, the Navy, and the Air Force hospitals. They are brought in on the complicated cases on a per diem basis.

I am talking about a sort of interim thing between that and full-time employment, where you have men employed on virtually a half-time basis. I believe, as I recall it, you authorized the payment of up to 6,500 a year for the half-time service. Those men are devoting more time than the consultants. They are actually doing the work, doing a considerable amount of surgery. It is a combination of the three things which has made possible the quality: First, the full-time medical men, next, the part-time medical men, and next, the consultants. It was the last group that you spoke of.

Mr. KARSTEN. I cannot escape the conclusion from your testimony that we are dreadfully short of doctors. I am quoting from your report. I am just wondering if you made any recommendations to improve the situation.

Mr. VOORHEES. I think we did, sir. In war there is going to be a terrific shortage.

Mr. KARSTEN. This report was written in peacetime. The report says: "The country is now dreadfully short of doctors." Recognizing that need, it seems to me that you should make a recommendation to cure the shortage.

Mr. VOORHEES. We did, sir, I think.

Mr. KARSTEN. You did not recommend more doctors, did you?

Mr. BURNSIDE. What about psychiatry. To get the only type we should have would be the psychiatrist with M. D. training. We cannot find them.

Mr. VOORHEES. The greatest shortage of all is in psychiatry, and there is a trend toward increase in mental illness.

Mr. BURNSIDE. For instance, in a State like West Virginia, we probably have only a few psychiatrists for eight or ten thousand cases. It is utterly impossible for them to get around to all of the cases that need their care and attention.

Mr. VOORHEES. I do not know the number. In the country there is an over-all shortage of psychiatrists.

Mr. BURNSIDE. He will have to be an M. D.

Mr. VOORHEES. They have to be doctors first and then specially trained in psychiatry.

Mr. BURNSIDE. We just do not have enough doctors to furnish the service in that field.

Mr. VOORHEES. That is right. The Federal Government is especially concerned with that because of the increasing number of Federal mental cases. I think that I mentioned a projection that the Metropolitan Life Insurance Co. made that even if we did not have another war three-quarters of our veteran cases would be mental in 25 years.

Mr. BURNSIDE. That bears out the point that Mr. Karsten raised. What percentage of all cases now are mental cases?

Mr. VOORHEES. Roughly, in the veterans' hospitals, something over 50 percent.

Mr. BURNSIDE. Then you will have only one doctor for a tremendous number of cases, and you have then 50 percent of all your cases coming within that classification.

Mr. VOORHEES. They are given the best care they can be, but my belief is, and I think everyone agrees, they need more trained psychiatrists.

Now, may I try to answer your question, sir?

The thing we were most concerned with was the shortage of doctors in the Federal medical service to take care of Federal patients.

Mr. KARSTEN. This is your third recommendation:

> In view of the drain of doctors away from private practice, the country is now dreadfully short of doctors.

Those are your own words.

Mr. VOORHEES. The greatest shortage is in the Federal services, in my judgment, and the way to alleviate that shortage, as we recommended, is by making arrangements so that various of the veterans, Federal patients, can be taken care of in community hospitals so that you can use the doctors already there and who can take care of more patients.

Mr. KARSTEN. That does not give us more doctors.

Mr. VOORHEES. But it takes care of the Federal patients. It makes better use of the doctors you have and so takes care of the patients.

Mr. KARSTEN. It is an indirect remedy?

Mr. VOORHEES. Yes; but it is about the quickest remedy because it takes a long time to get doctors. It was perfectly apparent when we made this study that the medical schools of the country were in a distressed financial condition. Our report shows it. They did not have any uniform financial statistics; they did not have any standard methods of bookkeeping by which you could tell what they really needed. It was perfectly apparent that there is greater need of Federal aid to the medical schools. But you cannot just give that as a sort of shotgun method without first determining what the needs are.

Therefore, we recommended, as I recall, a study, an immediate emergency study, and also a long-range study; the immediate study to see what ought to be done as an interim matter to bolster the medical schools and the long-range study to try to put it on a scientific basis.

The only way in the long run to get more doctors who are good doctors—we do not want any but good doctors—will be through a gradual building up of the medical schools. Unfortunately, the medical schools are limited primarily now by financial considerations. As you all know, there are 10 or more men applying for entrance at medical schools for every candidate that the medical schools can accept. It is primarily a financial limitation. I earnestly believe that is something the Congress should look into but I did not know that it was before us today.

Mr. TAURIELLO. Is that the reason for the shortage of doctors throughout the country?

Mr. VOORHEES. There are several factors. Of course, our population is much larger. We have a much older population. Older people need doctors very much more. You have a life expectancy in the United States for males of something over 66 years and for females 70 years. God apparently took care of the females better than the males. You have an aging population requiring more doctors. Furthermore, the people are much better educated as to the need for doctors and they go to doctors for all kinds of things that they did not go to them for before. It is a good thing for many people live instead of dying, and many of them avert serious illnesses. There is a greater demand for doctors and a greater use for them. As I say, we have both a larger population and a population with more age. Furthermore, we have this very large load of Federal cases who receive probably more in the way of medical attention than the civilian population.

Mr. HARVEY. I was particularly interested, Mr. Voorhees, in your statement that you thought one of the solutions was to farm out these Federal medical patients to local hospitals. Did your report give any statistical information as to the number of beds that were available in other than Federal hospitals?

Mr. VOORHEES. It was so complicated that we did not attempt to give it on a statistical basis. There are beds which are available in a great many places, but they depend upon the kind of case. If, for example, it is a mental case there are no beds available. If it is a tubercular case, there are no beds available. In those cases, the chronic cases, the Federal Government, as I say, has to do it. But the community hospitals in a great many places have a substantial number of beds available, and they are already staffed with the regular staff of the hospital and they are places at which veterans and other Federal wards could be taken care of right near their homes. There are the beds to do it.

Furthermore, with relatively little aid—much less than the cost of building Federal hospitals and staffing them and taking care of them—you could increase the number of local beds.

You have great institutions like the New York Hospital affiliated with Cornell Medical School. At the time of our study there were great wards created at tremendous expense closed because——

Mr. BURNSIDE. I found out from talking to Dr. Magnuson they do have wards that are available in certain parts of the country, but they have these wards not because they do not have the patients to fill them

but because they do not have the doctors and the specialists to use those wards that we have already built.

Mr. VOORHEES. You are talking about the Federal hospitals?

Mr. BURNSIDE. Federal and private. Take the private hospital in Baltimore. They had to close wards down on account of nurses, and they had to close them down at another place on account of the fact that they did not have enough doctors to attend to the patients in the wards.

Mr. VOORHEES. I think that we cannot generalize too much. In the Veterans' Administration there are a very considerable number closed down because of a lack of doctors.

Mr. BURNSIDE. That is true.

Mr. VOORHEES. In the voluntary hospitals there are quite a number closed down because of a lack of finances and some on account of a lack of nurses. The training of more nurses is, of course, a thing that the Federal Government also has a great stake in, and I am sure that we are going to need more. We ran out of nurses in the last year.

Mr. HARVEY. I have just had presented to me a statement from the citizens committee to the effect that approximately 83 percent of the country's hospital beds and 81 percent of the city hospital beds are utilized. I am wondering how near is it possible in the ordinary management of a hospital to approach 100-percent utilization.

Mr. VOORHEES. On that basis, and I think it is also true of big city hospitals, they are virtually fully utilized. In ordinary hospitalization language, for general hospitals for acute cases, 80 to 85 percent means a full hospital.

Mr. HARVEY. That was my impression. That is why I am raising the question, because I know from my own experience at the State level that we have gone ahead progressively building more hospitals. The demand over the last 20 years for hospital service has increased almost tenfold; that is, whereas in 1925 1 bed was sufficient, now it requires 10 to service the same area. That is a modest estimate. Also, in spite of the fact during the last 10 years most of the hospitals have been able to reduce the patient's stay by half, that means that they have in essence doubled their capacity, and if you want to use that as a criterion, you would say that the demand is 20 times as great as it was 25 years ago. I cannot believe that an easy answer to that problem lies in the assumption there are a lot of vacant beds scattered around in these city and county hospitals that are not utilized.

Mr. VOORHEES. If you speak of the city hospitals, meaning hospitals operated by the governments of the cities, I think insofar as the cities are concerned that I know of, they are pretty well crowded, and I do not think that you can take care of many more in those. I think the same thing applies to the county hospitals, although they are a little different in character because they are pretty largely filled with chronic cases. What I am speaking of is the great body of community hospitals throughout the country, of a nonprofit nature, organized by private charity, and a very large number of those do have a substantial number of free beds. You cannot generalize on it too much because they will have beds for one kind of thing and no beds for another. They have the capacity to take care of a great many more patients than they are now taking care of, and they could lighten the load on the Federal Government if they were fully utilized effectively.

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Mr. HARVEY. I might be convinced that might be a solution to the matter if our committee could have some very definite information, Mr. Chairman, relative to that, because there is no use going ahead on that assumption unless we have definite proof that such is the case. I am not questioning your judgment, but I do know, at least from my own rather limited knowledge, that such a surplus of beds does not exist.

Mr. VOORHEES. I agree as to the city and county hospitals. I am confident that is not so general as to the voluntary hospitals which have a very considerable amount of empty beds.

I was president for many years of a large hospital in Brooklyn, and after the war in an unguarded hour I took that presidency again and continued until the summer of 1948, when I thought that it was inconsistent for me to be in such a position at a time when I was making this study for the Hoover Commission. Also, I had more than I could handle and I had to give it up. I used to study those reports of Greater New York City, of the voluntary hospitals, month after month, and there were a very large number of beds that could have been made available. It is that kind of bed I am talking about. That applies also very forcefully to our smaller communities.

The CHAIRMAN. They do not have the specialists and the staffs in those hospitals.

Mr. VOORHEES. It is a question of having the patients taken care of where the staff is adequate to care for their types of cases. For example, if it is a simple appendectomy, they are fully able to do it. If it is a complicated diagnosis it might have to go to another hospital. There are hospitals now that do that consulting work.

Our problem is this: In order to utilize what we have already in hospital beds and staffs, we should divide the country into regions where you would have a central Federal general hospital for the Federal patients and they would have the knowledge of the local hospitals which could do this and that, as well as the Federal hospitals in the area, so they could move the patients within that area to make the maximum use of the beds available. All you would need to do is to pass permissive legislation, and since something could be accomplished in that way, I do not think it necessary to prove that there are X number of thousands of beds that would be available, as long as we know there is a substantial number.

Mr. BURNSIDE. What percentage of beds should be available for epidemics?

Mr. VOORHEES. I am not qualified to answer that. Hospitals for communicable diseases are usually kept separate from the others. The danger of epidemics is something that has been very much minimized by the development of preventive procedures and the antibiotics. We have not had a great epidemic since 1918—the flu epidemic. There has been no widespread epidemic that I can recall.

Mr. BURNSIDE. The reason I asked that is, since Congressman Harvey mentioned that 83 to 85 percent of the beds were occupied, you ought to have a certain margin there in case of an epidemic. We have had epidemics of polio and we have had epidemics of other types of contagious diseases. We still have those.

Mr. VOORHEES. Relative to the total hospital capacity they are small.

An epidemic of polio coming along in the summer or fall varies from year to year, but the hospital system is adequate to give those people care apparently at the present time.

Mr. BURNSIDE. What about the cases in the rural areas? Do you feel that we have enough doctors in the rural areas in the country?

Mr. VOORHEES. It is clearly true that we do not. The doctors can make more money in the cities and there is a lack of distribution, but, after all, you come back to the free-enterprise system. We have the quality of medical care because of the fact that these doctors are operating as free agents.

Mr. BURNSIDE. We are now paying about three-quarters of the cost of educating students. Why could not they, when they finish, go to the rural areas for 5 years?

Mr. VOORHEES. I think that you could very readily make an agreement with them in the general nature of the agreement made with the boys who go to West Point or Annapolis that they stay in the service for a period. That has been proposed.

There is another thing. Doctors will go where they have good hospital facilities and go where they can do good work. If you have the rural hospitals, I think that would go for to take care of your rural doctor problem.

Mr. BURNSIDE. That is the reason why your hospitals have increased because the people feel that they have to go to hospitals so that the doctors can give greater service because the doctors cannot go to the people.

Mr. VOORHEES. May I add to what I said to you, Mr. Harvey? I think that we should consider amending the law which aids the construction of voluntary hospitals under which the Federal Government pays a third. By paying that part and perhaps lending a part you could aid these institutions and still preserve the initiative of private charity and leave them responsible for running it. You could really increase your hospitals very considerably at relatively small Federal expense, for less than creating completely new hospitals.

Mr. HARVEY. I would agree with that.

Mr. VOORHIS. I would like to say one thing further, and this is a matter of general explanation. When our report was filed with the Hoover Commission I was Assistant Secretary of the Army, and I left for Germany the next day. I was over in Europe for some time on Army business. It was decided by the Commission to release that report to the public.

Now, We used in the report illustrations of waste of hospital beds, not confined to any one agency. Since I was connected with the Army, I was very careful in fairness to other agencies to include examples where we thought the Army wasted beds. In several of the agencies there were larger costs than we felt were necessary. That was only a part of the report. When I came back to America shortly after that you would have thought from reading the newspapers that that waste was the whole report. But it was only one incident of it. It was not done in a way to criticize the people who were running it so much as the system of having these several separate enterprises.

We pointed out how much could be done in the way of saving money and doctors by consolidation. I have the greatest respect for the

professional ability and the integrity and the quality of the surgeons general of the services. Also, as I have said repeatedly, of the medical work in the Veterans' Administration. I wanted to correct what I felt had left a wrong impression in the public mind.

The CHAIRMAN. Did I understand you to say that you believe under this administration the Government should have the power to go into private hospitals and command their beds?

Mr. VOORHEES. All I meant was that it would be a part of our stand-by mobilization; that if we had an atomic attack you could instantly do it.

The CHAIRMAN. And put civilians out of the hospital who were there under care and the Government take over those beds?

Mr. VOORHEES. I do not think the Government would need to take them over, but I think the Government would need to direct them. If you had an atomic attack hitting a number of our cities, to the best of my thinking, you would have to have emergency powers to utilize all hospital beds in order to give people the care necessary; otherwise, you would have a very great many unnecessary deaths.

The CHAIRMAN. You also said that there was a sharp division of whether this health administration should be placed in the Department or placed as a separate administration of itself. I believe you made that statement, that there was a sharp division of opinion on that question.

Mr. VOORHEES. Yes; there is a division of opinion, but not among the members of our task force. We thought either plan would work.

The CHAIRMAN. If you should have a medical administration including defense hospitals, and so forth, would you contemplate takin gover the Army personnel into your administration, and I mean the enlisted men, and so forth?

Mr. VOORHEES. No, sir; I do not think we should use the enlisted men.

The CHAIRMAN. If you are going to take over Army hospitals, under whose jurisdiction will be the doctors and the personnel treating the men who are in the Army?

Mr. VOORHEES. That is dealt with in considerable detail in our report. This is recommended: that this unified medical service, whether it is a part of the Department of Welfare, or Health, Education, and Security, or whether it is separate, that it apply only to the hospitals in the continental United States.

The CHAIRMAN. I mean the continental United States. When men are in the Army they are subject to control by their officers at all times, and when doctors are in the Army they are also under the same kind of military control. Are you contemplating putting civilians in charge of Army hospitals?

Mr. VOORHEES. No, sir. They would not be Army hospitals, the ones that I am talking about.

The CHAIRMAN. I mean to treat the Army personnel.

Mr. VOORHEES. That is different. They would treat Army personnel. In other words, there would have to be certain Army hospitals in this country at the posts which are rather remote, the large Army posts where there are no large civilian hospitals nearby.

The CHAIRMAN. I mean the posts near the big cities where they have the big hospitals. The Army has always maintained control of its personnel because you must have that military control. Now, are you

contemplating in this administration taking over the treatment of the enlisted personnel of the Army under civilian regulations?

Mr. VOORHEES. The answer to that is "Yes." It would be done in this way. I assume, instead of sending such cases which are seriously ill cases needing general hospital care to their own hospitals, they would send them to the central medical service. I assume they would also have the right to have and would have certain of their own doctors in there, because they would need that as a matter of education in those complicated cases.

The CHAIRMAN. Would Army personnel be in charge of the hospital?

Mr. VOORHEES. No; it would be under a civilian head.

The CHAIRMAN. Then you would have the patient in the hospital under civilian control?

Mr. VOORHEES. When a man is a patient, he is under the doctor's control.

The CHAIRMAN. But the doctor is himself a member of the Military Establishment; he is in the Army.

Mr. VOORHEES. Well, the man would simply be placed in the hospital under the control of civilian doctors. That is done in certain cases now. It is not done in a large number of cases, but it is done in certain cases where, for some reason, the Army cannot give the patient care and he is taken care of in a civilian hospital.

The CHAIRMAN. Unless the Army men give it, you are taking away military control.

Mr. VOORHEES. The only reason for doing that is because of the shortage of doctors.

The CHAIRMAN. Well, the Army is not complaining of a shortage of doctors at this time; is it?

Mr. VOORHEES. It is not at present.

Mr. KARSTEN. But that is the basic reason for it—the shortage of doctors?

Mr. VOORHEES. The shortage of doctors, particularly specialists, to give the best care and to give the care these patients need who are seriously ill in order to return them as quickly as possible and to effect a very large saving to the Federal Government in the cost of it.

You have this situation. For example, just take appendicitis. The average stay in a civilian hospital of a noncomplicated appendicitis case is about 8 days. As I recall, in a veterans' hospital it is about 18 days, and in an Army or Navy hospital about 27 or 28 days. There are various administrative procedures which affect the thing in the Army and Navy hospitals. One thing that affects it is that those people are far from home.

I have been with the Army for a long time, both in uniform and out, and was connected with the Surgeon General's office and had a lot to do with the Medical Department. There is not any serious administrative problem, in my judgment, in taking a seriously ill patient, a patient sick enough to be in a hospital, and ordering him to go into a civilian hospital and subjecting him to the medical care which is given there. You want to be sure they have good medical care, but there is nothing inconsistent with Army discipline, because the man when discharged from the hospital has to come back under Army orders. And he is sent there under Army orders, the same as we send people under Army orders for temporary duty to some city

and they carry out their orders there. They are merely directed to go to the city and do something in that case, and here they are directed to go to a hospital. I think that is perfectly possible.

The CHAIRMAN. I think it is possible, but I think it is highly improbable that the Army would ever agree to it or that it is a good, sound war measure or a defense measure ever to take a man who is in the Army from under military jurisdiction and under military discipline. I think it would be bad practice.

Mr. VOORHEES. Well, sir, I have the utmost respect for your views, and I would agree with that view if it were not for the shortage of doctors we have and the need to make the best possible utilization of the hospitals and doctors and of the Federal money. If you had no shortages in any of those problems at all and you could get the best care and money was not a primary factor, I think then it would be better for the Army to have its own. I would agree with you then.

The CHAIRMAN. Did your task force, since you were divided, make a specific recommendation to the Commission as to whether this health set-up should be in a department or whether it should be a separate administration of less than Cabinet standing?

Mr. VOORHEES. We were not divided. Our report was a unanimous report. This is the way it occurred. Mr. Hoover directed us to assume that the committee which was studying security and welfare separately from health would make a recommendation that there would be a Department of Health, Education, and Security. We were to assume that, and that is what we did assume in our main report. After the main report was filed, Mr. Hoover then asked us to consider another question, namely, would we favor doing this by a separate medical service outside of a department or a service which would be part of a department. We answered that by saying we would favor, if we had the choice, a separate medical service, but that we felt it could be done either way.

The CHAIRMAN. So, when you made this study, you made this study in contemplation that it would be part of a Department of Health, Education, and Security?

Mr. VOORHEES. That is right, sir.

The CHAIRMAN. Are there any other questions? If not, we certainly thank you very, very much, Mr. Voorhees.

Mr. VOORHEES. Thank you very much. I appreciate the privilege of appearing before you.

The CHAIRMAN. Gentlemen, I want to put into the record a joint statement entitled "The Establishment of a United Medical Administration," by Michael De Bakey, M. D., professor of surgery, Baylor University, and Edward D. Churchill, M. D., professor of surgery, Harvard University, who were members of this task force, as I see from the report.

(The statement above referred to is as follows:)

THE ESTABLISHMENT OF A UNITED MEDICAL ADMINISTRATION—JOINT STATEMENT BY MICHAEL DEBAKEY, M. D., PROFESSOR OF SURGERY, BAYLOR UNIVERSITY, AND EDWARD D. CHURCHILL, M. D., PROFESSOR OF SURGERY, HARVARD UNIVERSITY

INTRODUCTION

During World War II, Dr. DeBakey served as colonel, Medical Corps, Army of the United States, assigned to the professional service division of the Surgeon General of the Army.

Dr. Churchill, colonel, Medical Corps, Army of the United States, served overseas as chief surgical consultant, North African, Mediterranean Theater of Operations.

Dr. Churchill was chairman, and Dr. DeBakey was a member of the medical advisory committee appointed by the Secretary of War on August 21, 1946.

Both served as members of the task force on Federal medical services reporting to the Commission for Reorganization of the Executive Branch of the Government on November 30, 1948.

Both were appointed to the Medical Advisory Committee to the Secretary of Defense on December 13, 1948, and continue as members of that committee at the present time.

STATEMENT

The weaknesses found in the medical care program of the Federal Government were set forth in detail in the task force report on which the present H. R 5182 is based. The major weaknesses remain uncorrected, as they are inherent in the situation created by three large (Defense Department, Veterans' Administration, and Public Health Service) and various smaller agencies operating without a central plan. Consequently they continue to obtain funds and build hospitals, each to care for its own clientele. They compete with each other for scarce personnel. In general, no one of them considers the facilities in or the needs of the others, unless direct benefit accrues from the granting of bed allotments for the beneficiaries of another agency.

Since the report was written, progress has been made within the Department of Defense that compensates in part for the separation of the Air Force Medical Service as its third medical department charged with providing medical care. The recommendation made in chapter VII, C of the task force report that strong control over medical policy be exercised from the level of the Secretary of Defense was implemented first by the appointment of a Deputy for Medical Matters and an Advisory Committee by Secretary Forrestal and subsequently by the appointment of a Director of Medical Services by Secretary Johnson on July 6, 1949.

A crucial problem confronting the Armed Forces at the time the task force on Federal medical services issued its report (November 30, 1948) was the impending shortage of physicians. The selective-service legislation presented to the Eightieth Congress by the Defense Establishment included specific provisions for the compulsory service of doctors that were eliminated from the Selective Service Act as enacted.

On September 25, 1948, the Navy made a statement to the Task Force on Medical Services from which the following is an extract:

"We are making an all-out effort to procure sufficient personnel by publicity, personal contact, and training. * * * We are overworking our personnel to a dangerous point and one not conducive to retention or reenlistment. * * * We will require forthright and unequivocal legislative assistance by July 1, 1949, to maintain adequate standards of medical and dental care in the fulfillment of our commitment."

Similarly, the Surgeon General of the Army, on September 25, 1948, published a statement in the Journal of the American Medical Association from which the following is an extract:

"Informed individuals have known that a critical situation was in the making which would sooner rather than later, force the country to decide between a basic revision in its military policy and the devising of extraordinary measures to provide the armed services with adequate medical personnel. Congress was put on notice not once but repeatedly that the situation was deteriorating at an alarming rate and that by early 1949 the crisis would be upon us.

"We hope that the AMA will avail themselves of our invitation to review critically our estimated requirements. We have cut these requirements as low as we believe possible. * * *

"* * * The Army (including the Air Force) must secure about 4,000 physicians between now and June 1949. Since there is nothing in our experience to encourage us in the belief that such a large number could be secured by voluntary means, the Army requested permission to draft certain categories of doctors. * * *

"But the problem confronting the Army is not solely one of numbers. It also has a qualitative aspect. We are still very short of specialists despite our refresher training and our comprehensive postgraduate training. In a recent communication I pointed out to the President of your association that approximately

400 of the required 4,000 doctors who had to be procured before July of next year, should be specialists."

Against this background the Task Force on Medical Services made the following statement:

"No savings which can be produced by our recommendations will be sufficient in time or in quantity to avert the need for a draft of doctors. But it can be greatly limited. There is a pool of about 8,500 former ASTP and V–12 students. * * * But they should be drafted only for services truly essential to the primary mission of the armed forces.

"Our area surveys, our manpower questionnaire study, and our review of hospitalization in the armed forces, have convinced us that the present medical personnel requirements of the armed forces are not justified in full. We believe that a thorough review of these requirements by the Deputy to the Secretary of Defense and his new committee should precede any draft legislation."

The task force also expressed the common concern about maintaining quality of medical care, and pointed out that a draft would not supply medical specialists: "A draft is necessary, but it will bring in only young doctors who cannot provide high-grade specialist care."

In consultation with the Advisory Committee of the Secretary of Defense and the Director of Medical Services, the Surgeons General have effected major economies in the utilization of medical manpower although this has meant the reduction and consolidation of hospital facilities at times beyond the point considered optimal by the Surgeons General. Assistance in maintaining the quality of care and in the establishment of residency-training programs for the dual purpose of carrying the work load of medical care and recruiting personnel has been provided by the loyal and voluntary efforts of civilian consultants, in large part veterans of World War II.

To meet its initial requirements for medical officers, the Air Force Medical Department was assisted by officers from Navy and Army attached on temporary duty.

An intensive recruitment campaign directed specifically at ASTP and V–12 physicians who had not performed active military service was sponsored both by Secretary Johnson and his predecessor.

So while the shortage of doctors in the Armed Forces has been met at least temporarily, and no further request for a special draft of doctors has reached the Congress, stringent economies have been required, as well as a retrenchment of programs that were considered desirable by the individual medical departments of the forces. Any real increase in over-all troop strength or an increased overseas dispersion of troops can be expected to reopen the problem of the procurement of doctors and dentists for the Armed Forces. The number that can be secured by the normal operation of existing selective-service legislation will be negligible.

As members of the Committee on Federal Medical Services that prepared the task-force report for the Commission on Organization of the Executive Branch of the Government, we have followed with keen interest both the favorable and the critical comments it has evoked. The unfavorable comments and criticisms seem to have one thought in common—that it is possible to maintain the status quo. The assumption is made that the health resources of the Nation can in peace and war provide for a number of parallel hospital systems each concerned with a separate clientele of patients and each staffed to provide highly specialized and expert professional skills. We question that assumption.

Chapter VIII of the task-force report, entitled "Health Resources and Manpower Allocation in Time of Emergency" has become more timely in 1950 when viewed against the background of the disturbed international situation and the rising tide of civil-defense planning than it was in November 1948. The focal point of defense planning in the health area will be manpower allocation between the needs of the military and the civilian population. Effective distribution and utilization of manpower within these two segments will be equally vital. To quote from the task-force report:

"The evidence shows that medical manpower is one of the scarcest of the resources essential to the country in war. Its production cannot be increased in response to emergency demands. It cannot be stockpiled. A sound program of conservation centers on allocation and distribution in accordance with absolute requirements, not in response to claimant estimates of needs."

The Director, Health Resources Division, National Security Resources Board, has recently stated that civil defense is not a responsibility of our Armed Forces. "In time of war," he said, "our Armed Forces must concentrate on their primary mission of repelling attack and carrying war to the enemy. Their efforts to

carry out this mission must not be diverted to take care of the civilian population." The Task Force on Federal Medical Services recognized that "the medical service of an armed force is a necessary and an integral part of that force," and that "* * * so much of a medical service as in direct support of an armed force is, and must continue to be, inseparable from that force."

Opinions have differed regarding the definition of the activities of a medical service that may be considered "in direct support of an armed force." During peace, for example, it has been argued that the long-term treatment of pulmonary tuberculosis in military hospitals, even though the individual is never expected to return to active duty, is essential to maintain morale among service personnel. The allotment of beds in military hospitals to veterans with non-service-connected disabilities has been justified by the claim that it is essential to maintain training programs that attract young doctors who may join the Medical Corps. In time of war it is unlikely that either of these activities would be a responsibility elected by the military.

In World War II direct support of an armed force meant the provision of medical service up to the maximum benefit of hospital care for service-connected disabilities. This resulted in the retention of patients in military hospitals for 1, 2, or even 3 years after their military usefulness had ended. Both the Army and the Navy built up enormous hospital systems in continental United States staffed by voluntary recruitment of physicians. This solution, however, as stated in the report of a Task Force Subcommittee on Armed Forces Hospitalization, was "barely tolerable for the civil population. The country was most fortunate during those war years in escaping both epidemics and enemy attack upon the civil population. Had either of these contingencies occurred, those at home would have suffered from lack of sufficient medical care. With the rapid development of new weapons for total war, the medical needs of the civil population must henceforth be given much greater consideration in the distribution of medical resources in war."

In time of emergency the allocation of medical personnel between the civilian population and the military must be based on a rigid definition of what is "direct support" of the armed forces. There can be no disagreement that direct support of the military requirements must receive first priority. However, Dr. Paul Hawley's subcommittee of the task force considered that a certain existing function of military medical service in continental United States cannot be considered direct support of an armed force. This is the purely professional care in hospitals of the serious cases requiring expert medical or surgical skills (specialists). A high proportion of such cases are forever unfit for further military service; and such as do fully recover are of little military value during the period of their hospitalization. Such patients are primarily a medical, rather than a military responsibility; and, while there are many sound reasons for not separating those of further usefulness from military control, there is no impelling reason for treating them in military hospitals. It was accepted by the task force that this group of patients could properly become the responsibility of the United Medical Administration.

It is obvious that direct support of the armed forces is subject to different interpretations when viewed against the circumstances of peace, dispersion of troops carrying out occupational or police action tasks, or total mobilization. The extent of the workload of medical service considered essential to the mission of the Department of Defense will determine the manpower requirements that are ultimately expressed as the ratio of doctors to troop strength. The decisions as to allocation of health manpower resources between civilian and military needs must of necessity rest at a higher level, at present the NSRB.

For, in addition to direct support of the armed forces in an emergency, thousands of physicians will be required in the Nation-wide program of civil defense. Many will be needed for duty with mobile casualty units which can be sent to the assistance of stricken cities. As the chairman of the American Medical Association Council on National Emergency Medical Service recently stated:

"If there is an air burst over Chicago's Loop, the doctors in Chicago will be dead or dying. It will have to be the doctors of Waukegan, Elgin, Aurora, Joliet, and Valparaiso that will have to be organized and ready to serve.

In making recommendations concerning the structure of the hospital system referred to in this bill as the United Medical Administration, the task force stressed both regional autonomy and close integration with voluntary medical services. Isolation of Federal medicine as something apart from the community is no longer tolerable either in peace or war. Emergency conditions will demand

that all hospital facilities in critical areas be pooled and placed under civil defense operation control or under military control, if such decision is made.

The proposed United Medical Administration would therefore contribute a reserve of hospital facilities prepared to receive a workload of patient care that might well be considered burdensome by the military in time of emergency, but considered desirable by their medical departments during peace. It would also stand in close relationship to civilian needs as its single hospital system could move quickly in response to the needs of civilian authorities. Under its unified administrative control patient groups could be transferred at the first alert warning, making beds available for the emergency needs of military and civilian groups alike. Leadership in preparedness and training programs would be assured.

A basic consideration that has led us to support the principle of a United Medical Administration is that in time of emergency the individual doctor must be able to care for the maximum number of patients compatible with his physical endurance and specialized skills.

(The following statements were received by the committee:)

University of Washington,
Seattle, March 28, 1950.

Hon. William L. Dawson,
House of Representatives, Washington, D. C.

Dear Representative Dawson: I regret my delay in answering your letter of March 16 and my inability to appear before your committee to testify on H. R. 5182 on the proposed United Medical Administration. I do not have a copy of this bill, but I take it that it incorporates the recommendations of the Hoover Commission on this matter.

Even though I support practically all of the recommendations of the Hoover Commission and hope that this session of the Congress will give every consideration to the President's and the Members of Congress' recommendations on reorganization, I am opposed to the establishment of a United Medical Administration because I think such a proposal is untimely and would be impossible to administer efficiently at this time. I would strongly recommend that your committee consider something short of this proposal which will for the present accomplish in an evolutionary manner the ends sought by H. R. 5182. My experience as the first Director of Medical Services for the Armed Forces last summer, organizing that office for the Secretary of Defense, convinced me that the establishment of an Office of Federal Medical Affairs at the President's office level will reinforce the President's existing powers to make and supervise policy in this important area which currently involves the expenditures of $2,000,000,000 to $3,000,000,000 annually. There is no question but that there is inefficiency, waste, and duplication in the present administration of hospital and other medical facilities throughout the Federal Government, running into the hundreds of millions of dollars annually. I urgently propose and recommend that an Office of Medical Affairs be created in the Office of the President, with a Director having authority and responsibility for the following duties:

(*a*) The establishment and control of general policies, standards, and program for the medical services of the executive branch of the Federal Government.

(*b*) The exercise of general direction, authority, and control over the administration of and utilization of personnel and facilities in the medical services of the departments and agencies of the Federal Government.

(*c*) And such other duties with respect to the medical services of the Federal Government as the President may direct.

Such an Office should have an advisory medical council consisting of the best-qualified men in the Nation to advise the Director on the civilian approach to the solution of these problems. The Office should provide leadership of the existing interdepartmental committee of the executive departments concerned with medical affairs.

In connection with other proposals relating to the creation of a department on health, education, and welfare at the Cabinet level, I am strongly opposed to the incorporation of medicine in such an organization. I think health is a sufficiently important problem of American citizens and to the national security to justify a Federal department of its own. In my opinion, the first step, and one that could well be initiated by the President in the near future, is the establishment of an Office of Medical Affairs with the powers enumerated above. I believe a resolution of the Congress supporting such a reorganization effort would greatly

strengthen the hand of the Executive in dealing with this whole complicated and vexed question. If such an office is to be created and if a man of sufficient capability and standing is to be attracted, a salary of upwards of $20,000 would be necessary. Such an office would not require a large staff since it would not enter into operations itself. Rather it would set and administer policy and thereby be a great aid to the President in discharging his responsibilities.

I am sending along several copies of this letter for the information of members of your committee and others who may wish to see it.

Perhaps I should have mentioned above that my interest in this problem grows out of my service as a member of the Eberstadt task force committee of the Hoover Commission which had responsibility for studying the national security organization in 1948, my membership on the Armed Forces Medical Advisory Committee to the Secretary of Defense, and my service as Director of Medical Services of the Armed Forces in the summer of 1949.

Thank you for the opportunity to submit this testimony. I trust that some time when I am in Washington I can call on you and discuss these recommendations in more detail and have the pleasure of meeting you.

Sincerely,

RAYMOND B. ALLEN, *President,*
University of Washington.

JUNE 12, 1950.

Hon. WILLIAM DAWSON,
Chairman, House Committee on Expenditures,
Washington, D. C.

DEAR REPRESENTATIVE DAWSON: Attached hereto are appendixes A to C, the bed studies promised your committee; and appendix D, suggested amendments to H. R. 5182.

Respectfully submitted.

ROBERT L. L. MCCORMICK.
Research Director, Citizens Committee for the Hoover Report.

APPENDIX A

Summary of statistics on total hospital beds in the United States in calendar year 1949. This study was prepared by the research staff of the Citizens Committee for the Hoover Report. Basic data on non-Federal hospitals are from the 1949 census of hospitals registered by the American Medical Association, published in the May 6, 1950, issue of the AMA Journal. Basic Federal hospital bed statistics are from the Report on Utilization of Federal Hospital Beds published in May 1950 by the Senate Expenditure Committee's Subcommittee on Investigations.

TABLE NO. 1.—*Summary of hospital beds in 1949 classified by control*

	Hospitals	Beds	Average daily use	Percent of utilization
Governmental:				
Federal	339	193, 521	133, 217	69
State	573	656, 611	618, 614	94
County	561	103, 209	85, 650	83
City	373	71, 779	58, 160	81
City-county	69	11, 302	8, 469	74
Total governmental	1, 915	1, 036, 422	904, 110	87
Nongovernmental:				
Church	1, 090	146, 315	114, 408	78
Nonprofit associations	2, 067	213, 576	159, 560	74
Total nonprofit	3, 157	359, 891	273, 968	76
Individual and partnership corporations	1, 077	29, 669	17, 947	60
Profit unrestricted	401	24, 315	17, 193	70
Total proprietary	1, 478	53, 984	35, 140	65
Total nongovernmental	4, 635	413, 875	309, 108	74
Total all hospitals	6, 550	1, 450, 297	1, 213, 218	83

TABLE No. 2.—*Breakdown of total and Federal hospital beds, total and veterans population by States, for calendar 1949*

	Total all hospital beds (1)	Total Federal hospital beds (2)	Percentage column (2) as to column (1) (3)	Total population (4)	Veteran population (5)
Alabama	19, 509	4, 098	21	2, 920, 000	316, 000
Arizona	6, 467	1, 364	21	745, 000	72, 000
Arkansas	13, 923	4, 044	29	1, 964, 000	190, 000
California	101, 147	21, 318	21	10, 665, 000	1, 360, 000
Colorado	18, 948	5, 310	28	1, 215, 000	163, 000
Connecticut	22, 957	339	1	2, 019, 000	291, 000
Delaware	4, 322	150	3	311, 000	39, 000
District of Columbia	16, 376	9, 771	59	870, 000	139, 000
Florida	21, 319	3, 995	18	2, 494, 000	303, 000
Georgia	27, 378	7, 173	26	3, 196, 000	346, 000
Idaho	4, 032	245	6	592, 000	69, 000
Illinois	98, 496	11, 632	11	8, 449, 000	1, 226, 000
Indiana	29, 823	2, 507	8	3, 994, 000	465, 000
Iowa	22, 077	2, 003	9	2, 643, 000	367, 000
Kansas	19, 072	4, 240	22	1, 947, 000	243, 000
Kentucky	23, 465	7, 145	30	2, 893, 000	324, 000
Louisiana	20, 960	2, 664	12	2, 630, 000	306, 000
Maine	8, 727	912	10	909, 000	113, 000
Maryland	25, 910	5, 550	21	2, 175, 000	266, 000
Massachusetts	64, 256	7, 246	11	4, 713, 000	681, 000
Michigan	63, 108	5, 552	8	6, 352, 000	797, 000
Minnesota	32, 795	2, 154	6	2, 977, 000	385, 000
Mississippi	13, 512	2, 891	21	2, 130, 000	228, 000
Missouri	36, 120	1, 545	4	3, 935, 000	488, 000
Montana	5, 598	316	5	521, 000	78, 000
Nebraska	12, 287	348	3	1, 285, 000	160, 000
Nevada	1, 188	256	21	174, 000	21, 000
New Hampshire	6, 201	401	6	544, 000	70, 000
New Jersey	50, 851	4, 819	9	4, 873, 000	693, 000
New Mexico	4, 347	934	21	589, 000	65, 000
New York	204, 681	13, 832	6	14, 392, 000	2, 072, 000
North Carolina	28, 883	5, 118	17	3, 864, 000	412, 000
North Dakota	5, 566	400	7	605, 000	65, 000
Ohio	66, 407	5, 401	8	7, 989, 000	994, 000
Oklahoma	17, 473	1, 301	7	2, 302, 000	300, 000
Oregon	12, 745	1, 014	8	1, 736, 000	192, 000
Pennsylvania	101, 394	7, 388	7	10, 633, 000	1, 445, 000
Rhode Island	9, 519	1, 226	12	743, 000	121, 000
South Carolina	14, 813	3, 077	20	2, 001, 000	204, 000
South Dakota	6, 927	1, 155	16	649, 000	74, 000
Tennessee	23, 835	5, 496	23	3, 234, 000	365, 000
Texas	56, 591	15, 404	27	7, 532, 000	906, 000
Utah	4, 391	150	3	682, 000	85, 000
Vermont	4, 062	188	4	369, 000	41, 000
Virginia	31, 375	8, 534	27	3, 102, 000	362, 000
Washington	24, 857	5, 385	21	2, 582, 000	289, 000
West Virginia	13, 818	1, 290	9	1, 941, 000	243, 000
Wisconsin	36, 864	2, 887	7	3, 355, 000	406, 000
Wyoming	3, 587	1, 232	34	284, 000	41, 000
Total	1, 462, 959	201, 250	13. 7	148, 719, 000	18, 881, 000

TABLE No. 3.—*Average length of stay per patient in general hospitals, 1947, 1948, 1949, classified by control or ownership*

[In days]

Control	1947	1948	1949
Federal	29.8	27.9	25.8
State	16.0	15.5	15.4
County	16.6	14.9	14.8
City-county	11.7	10.0	11.8
All governmental general	19.5	17.9	17.2
Church	9.0	8.4	8.3
Other nonprofit associations	9.1	8.6	8.3
All nonprofit general	9.0	8.5	8.3
Individual and partnership	6.0	5.8	5.4
Corporations (profits unrestricted)	7.3	6.4	6.4
All proprietary general	6.5	6.1	5.9
All nongovernmental	8.7	8.2	8.0
All general hospitals	11.4	10.5	10.1

APPENDIX B

STATISTICS ON THE NUMBER AND UTILIZATION OF FEDERAL HOSPITAL BEDS

All the facts and figures on bed capacities and bed utilization in each Federal hospital, by type of hospital, by operating agency, and by location, are absolutely requisite to planning any and all Federal medical programs.

The conspicuous absence of any single Federal source of authoritative statistics on the number and occupancy of Federal hospital beds points up a serious deficiency in the present conduct of medical activities. It is a serious indictment of the present method of administering medical services that the totals of these statistics are not available.

The research staff of the Citizens Committee for the Hoover Report has prepared tables, which are attached, showing bed capacity, bed occupancy by type of hospital, operating agency, and by area. These tables are based on information found in the one source of such statistics—namely, the Senate Committee on Expenditures Investigating Subcommittee's report, entitled "Utilization of Federal Hospital Beds" dated May 23, 1950.

The totals on 1949 Federal bed capacities reported in the attached tables are compiled from figures reported by the Senate Expenditures Committee's Investigating Subcommittee. The Hoover Commission's task force on medical services made its own survey of Federal capacities for the year 1948. There was a greater number of beds reported in the Hoover Commission task force study in 1948 than there was in the Senate Expenditures Committee's Investigating Committee report for 1949 for two reasons:

1. The Senate committee's report only includes the bed capacities of hospitals in the five major Federal agencies, namely, Army, Air Force, Navy, Public Health Service, and Veterans' Administration. The task force study included additional beds as follows:

	Beds
(*a*) VA domiciliary homes	16,494
(*b*) Bureau of Prisons	2,754
(*c*) St. Elizabeths	7,000
(*d*) Freedman's	498
(e) Indian Service	3,872

2. The remaining difference between reported 1948 and 1949 bed capacities may be accounted for as reflecting normal changes from one postwar year to another. This change is reflected as follows:

(*a*) A reduction of eight Army hospitals with 11,400 beds in 1949.

(*b*) A reduction of 4,506 beds among the 54 Air Force hospitals in 1949.

(*c*) A reduction of 37 Navy dispensaries and hospitals with 9,254 beds in 1949.

Utilization of Federal Hospital Beds Calendar Year 1949 by Agency and Type of Hospital

Prepared by research staff, Citizens Committee for the Hoover Report. This study is based on Interim Report on Utilization of Federal Hospital Facilities, submitted to the Senate Committee on Expenditures in the Executive Departments by its Subcommittee on Investigations.

Table No. 1.—*Bed capacity and average daily use by agency during calendar year 1949*

	Number of hospitals	Bed capacity	Average daily use	Percent of utilization
Army	47	43,025	14,369	33
Air Force	54	11,448	2,504	22
Navy	91	25,388	13,602	54
Public Health Service	23	8,122	7,343	90
Veterans' Administration	124	105,538	95,399	90
Total	339	193,521	133,217	69

Table No. 2.—*Bed capacity and average daily use by type of hospital in calendar year 1949*

	Number of hospitals	Bed capacity	Average daily use	Percent of utilization
Stations	157	38,899	7,183	18
General	126	93,289	67,925	73
Neuropsychiatric	34	49,874	49,062	98
Tubercular	20	9,609	7,483	78
Narcotics	1	1,400	1,175	84
Leprosarium	1	450	389	86
Total	339	193,521	133,217	69

Table No. 3.—*A breakdown of bed capacities and average daily use by types of hospitals operated by each agency during calendar year 1949*

	Bed capacity	Average daily utilization		Bed capacity	Average daily utilization
Army:			Public Health Service—Con.		
Station	25,628	3,819	Neuropsychiatric	1,000	902
General	17,397	10,550	Tubercular	492	439
Air Force: Station	11,448	2,504	Leprosarium	450	389
Navy:			Narcotics	1,400	1,175
Station	1,823	860	Veterans' Administration:		
General	23,565	12,742	General	47,547	40,195
Public Health Service:			Neuropsychiatric	48,874	48,160
General	4,780	4,438	Tubercular	9,117	7,044

TABLE NO. 4.—*A breakdown of bed capacities and average daily use by types of hospital and Federal agency during calendar year 1949*

Stations			General		
	Bed capacity	Average daily use		Bed capacity	Average daily use
Army	25,628	3,819	Army	17,397	10,550
Air Force	11,448	2,504	Navy	23,565	12,742
Navy	1,823	860	Public Health Service.	4,780	4,438
			Veterans' Administration.	47,547	40,195
Total	38,899	7,183	Total	93,289	67,925
Neuropsychiatric			**Tubercular**		
Public Health Service	1,000	902	Public Health Service.	492	439
Veterans' Administration.	48,874	48,160	Veterans' Administration.	9,117	7,044
Total	49,874	49,062	Total	9,609	7,483
Narcotic			**Leprosarium**		
Public Health Service	1,400	1,175	Public Health Service.	450	389

APPENDIX C

AVERAGE UTILIZATION OF FEDERAL HOSPITAL BEDS IN CALENDAR YEAR 1949 BY STATES AND TYPES OF HOSPITALS

Prepared by research staff, Citizens Committee for the Hoover Report. This study is based on Interim Report on Utilization of Federal Hospital Facilities, submitted to the Senate Committee on Expenditures in the Executive Departments by its Subcommittee on Investigations.

States	Station		General		Neuropsychiatric		Tubercular	
	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization
Alabama:								
Air Force	674	92						
Public Health Service			145	130				
Veterans' Administration			268	270	3,011	2,983		
Total	674	92	413	400	3,011	2,983		
Arizona:								
Army	57	6						
Air Force	364	60						
Veterans' Administration			144	136			799	676
Total	421	66	144	136			799	676

Appendix C—Continued

Average Utilization of Federal Hospital Beds in Calendar Year 1949 by States and Types of Hospitals—Continued

States	Station		General		Neuropsychiatric		Tubercular	
	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization
Arkansas:								
Army	1,284	105	410	363				
Veterans' Administration			255	238	2,095	1,983		
Total	1,284	105	665	601	2,095	1,983		
California:								
Army	2,604	261	1,115	1,043				
Air Force	979	232						
Navy	385	239	7,638	4,292				
Public Health Service			431	373				
Veterans' Administration			6,050	5,596	1,161	1,425	955	755
Total	3,968	732	15,234	11,304	1,161	1,425	995	775
Colorado:								
Army	1,806	64	2,140	1,712				
Air Force	257	139						
Veterans' Administration			326	287	781	852		
Total	2,063	203	2,466	1,999	781	852		
Connecticut:								
Navy	50	24						
Veterans' Administration			289	290				
Total	50	24	289	290				
Florida:								
Air Force	730	160						
Navy	96	45	1,911	822				
Veterans' Administration			1,258	1,138				
Total	826	205	3,169	1,960				
Georgia:								
Army	1,593	291	2,539	[1] 923				
Air Force	241	17						
Navy	2	0						
Public Health Service			117	128				
Veterans' Administration			1,250	798	1,206	1,265	225	215
Total	1,836	308	3,906	1,849	1,206	1,265	225	215
Idaho: Veterans' Administration			245	214				
Illinois:								
Air Force	1,130	239						
Navy	210	93	1,545	613				
Public Health Service			204	184				
Veterans' Administration			3,571	2,998	4,972	4,241		
Total	1,340	332	5,320	3,795	4,972	4,241		
Indiana:								
Navy	10	1						
Veterans' Administration			847	743	1,650	1,745		
Total	10	1	847	743	1,650	1,745		
Iowa: Veterans' Administration			372	448	1,631	1,646		

[1] Oliver General Hospital.

APPENDIX C—Continued

AVERAGE UTILIZATION OF FEDERAL HOSPITAL BEDS IN CALENDAR YEAR 1949 BY STATES AND TYPES OF HOSPITALS—Continued

States	Station		General		Neuropsychiatric		Tubercular	
	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization
Kansas:								
Army	1,487	370						
Navy	15	6						
Veterans' Administration			1,338	1,247	1,400	1,113		
Total	1,502	376	1,338	1,247	1,400	1,113		
Kentucky:								
Army	2,744	396						
Public Health Service: (Narcotics—1,400 beds; 1,175-bed capacity)								
Veterans' Administration			1,395	1,072	1,230	1,153	376	300
Total	2,744	396	1,395	1,072	1,230	1,153	376	300
Louisiana:								
Army	226	22						
Air Force	200	44						
Navy	20	12						
Public Health Service: (Leprosarium—450 beds; 389-bed capacity)			436	393				
Veterans' Administration			1,332	1,011				
Total	446	78	1,768	1,404				
Maine:								
Public Health Service			61	59				
Veterans' Administration					851	787		
Total			61	59	851	787		
Maryland:								
Army	1,244	146						
Navy	85	41	1,602	1,030				
Public Health Service			400	368				
Veterans' Administration			389	407	1,830	1,867		
Total	1,329	187	2,391	1,805	1,830	1,867		
Massachusetts:								
Army			1,169	[2] 461				
Air Force	266	51						
Navy			882	614				
Public Health Service			332	278				
Veterans' Administration			1,416	1,182	2,563	2,955	618	509
Total	266	51	2,630	2,074	2,563	2,955	618	509
Michigan:								
Army			2,133	[3] 809				
Air Force	63	17						
Navy	10	3						
Public Health Service			212	217				
Veterans' Administration			1,117	893	2,017	2,044		
Total	73	20	3,462	1,919	2,017	2,044		

[2] Murphy General Hospital.
[3] Percy Jones General Hospital.

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Appendix C—Continued

Average Utilization of Federal Hospital Beds in Calendar Year 1949 by States and Types of Hospitals—Continued

States	Station		General		Neuropsychiatric		Tubercular	
	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization
Minnesota:								
Navy	10	4						
Veterans' Administration			762	985	1,382	1,337		
Total	10	4	762	985	1,382	1,337		
Mississippi:								
Air Force	1,000	103						
Veterans' Administration			952	686	939	1,063		
Total	1,000	103	952	686	939	1,063		
Missouri:								
Navy	10	2						
Public Health Service			127	128				
Veterans' Administration			557	627			851	638
Total	10	2	684	755			851	638
Montana:								
Air Force	78	37						
Veterans' Administration			238	183				
Total	78	37	238	183				
Nebraska:								
Air Force	58	39						
Navy	10	1						
Veterans' Administration			280	268				
Total	68	40	280	268				
Nevada:								
Air Force	85	15						
Navy	5	1						
Veterans' Administration			166	120				
Total	90	16	166	120				
New Hampshire: Navy			401	79				
New Jersey:								
Army	2,550	557						
Navy	35	13						
Veterans' Administration					2,234	2,501		
Total	2,585	570			2,234	2,501		
New Mexico:								
Air Force	217	33						
Public Health Service							242	172
Veterans' Administration			252	273			223	191
Total	217	33	252	273			465	363
New York:								
Army	598	285						
Air Force	368	80						
Navy			2,114	1,036				
Public Health Service			1,189	1,045			250	267
Veterans' Administration			4,159	3,710	4,012	4,211	1,142	1,014
Total	966	365	7,462	5,791	4,012	4,211	1,392	1,281

APPENDIX C—Continued

AVERAGE UTILIZATION OF FEDERAL HOSPITAL BEDS IN CALENDAR YEAR 1949 BY STATES AND TYPES OF HOSPITALS—Continued

States	Station		General		Neuropsychiatric		Tubercular	
	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization
North Carolina:								
Army	1,558	346						
Navy	82	50	1,066	215				
Veteran's Administration			416	284			1,996	1,281
Total	1,640	396	1,482	499			1,996	1,281
North Dakota: Veteran's Administration			400	211				
Ohio:								
Air Force	510	71						
Navy	10	3						
Public Health Service			189	209				
Veteran's Administration			2,316	1,790	2,116	2,133	260	253
Total	520	74	2,505	1,999	2,116	2,133	260	253
Oklahoma:								
Army	550	115						
Air Force	135	9						
Navy	10	1						
Veteran's Administration			606	531				
Total	695	125	606	531				
Oregon:								
Navy	25	14						
Veteran's Administration			412	461	577	594		
Total	25	14	412	461	577	594		
Pennsylvania:								
Army	106	25	1,700	1,142				
Air Force	59	9						
Navy	10	2	1,500	1,140				
Veterans' Administration			1,619	1,671	2,394	2,340		
Total	175	36	4,819	3,953	2,394	2,340		
Rhode Island:								
Navy	110	78	723	493				
Veterans' Administration			393	76				
Total	110	78	1,116	569				
South Carolina:								
Army	1,375	167						
Air Force	85	18						
Navy	344	131	667	328				
Veterans' Administration			606	634				
Total	1,804	316	1,273	962				
South Dakota:								
Air Force	165	19						
Veterans' Administration			270	230	720	633		
Total	165	19	270	230	720	633		

Appendix C—Continued

Average Utilization of Federal Hospital Beds in Calendar Year 1949 by States and Types of Hospitals—Continued

States	Station		General		Neuropsychiatric		Tubercular	
	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization	Constructed bed capacity	Average daily utilization
Tennessee:								
Air Force	92	13						
Navy	20	5	588	264				
Public Health Service			134	115				
Veterans' Administration			3,055	2,212	1,307	1,027	300	284
Total	112	18	3,777	2,591	1,307	1,027	300	284
Texas:								
Army	[4] 2,531	[4] 141	3,295	1,915				
Air Force	2,638	589						
Navy	70	28	700	257				
Public Health Service			107	149	1,000	902		
Veterans' Administration			2,426	1,686	1,942	1,930	695	345
Total	5,239	758	6,528	4,007	2,942	2,832	695	345
Utah: Veterans' Administration			150	174				
Vermont: Veterans' Administration			188	214				
Virginia:								
Army	2,657	386						
Air Force	100	47						
Navy	105	29	1,652	1,221				
Public Health Service			316	246				
Veterans' Administration			1,704	1,284	2,000	1,848		
Total	2,862	462	3,672	2,751	2,000	1,848		
Washington:								
Army	603	118	1,374	985				
Air Force	473	82						
Navy	74	32	576	338				
Public Health Service			380	416				
Veterans' Administration			575	476	904	807	421	362
Total	1,155	232	2,905	2,215	904	807	421	362
West Virginia: Veterans' Administration			1,290	952				
Wisconsin:								
Army	50	18						
Veterans' Administration			1,409	1,070	1,172	967	256	221
Total	50	18	1,409	1,070	1,172	967	256	221
Wyoming:								
Air Force	304	214						
Veterans' Administration			151	136	777	710		
Total	304	214	151	136	777	710		
District of Columbia:								
Army			1,522	1,197				
Air Force	177	75						
Navy	10	2						
Veterans' Administration			333	283				
Total	187	77	1,855	1,480				

[4] Camp Hood.

Appendix D

PROPOSED AMENDMENTS TO THE UNITED MEDICAL ADMINISTRATION BILL, H. R. 5182

Part I

At the time the Hoover Commission was established, the Senate Committee on Expenditures in the Executive Departments formally requested that the Commission prepare and submit proposed drafts of legislation to implement its recommendations. Since the Commission's demise, the Citizens Committee for the Hoover Report has assumed the responsibility to meet the outstanding obligations of the Hoover Commission in submitting perfecting amendments.

The United Medical Administration bill was drafted by counsel for the Hoover Report. Since its submission to Congress, certain basic conditions have changed, as, for example, the unification of the armed services, which makes amendment to S. 2008 (H. R. 5182) necessary.

The Citizens Committee herewith submits several required amendments to this bill. The technical amendments to S. 2008 (H. R. 5182), recommended by the Citizens Committee, are set forth in part II hereof. Among the important technical amendments are:

A. An amendment to define the powers and duties of the Administrator. This provision authorizes the Administrator to operate all functions transferred to the United Medical Administration. It specifies the Administrator's duties:

1. To conduct the public health activities transferred to the United Medical Administration;
2. To encourage and assist other appropriate authorities engaged in studies relating to the physical and mental diseases and impairments of man; and
3. To conduct the present residency and internship program.

B. An amendment to change the membership of the Advisory Board, due to the unification of the armed services through public law enacted August 10, 1949, and to insure representation of all Federal departments engaged in medical and health activities. The Advisory Board shall consist of the Secretary of Defense and the Administrator of Veterans' Affairs or their designees. The Surgeon General of the Public Health Service is also included although changes in his status may occur in later years.

C. A major amendment to provide in the transfer of functions to the United Medical Administration the inclusion of the Department of Medicine and Surgery of the Veterans' Administration and it excludes in the transfer all functions relating to the establishment of veterans' eligibility for hospitalization or medical or health care, which remains in the Veterans' Administration.

D. An amendment to provide that the Public Health Service and the Department of Medicine and Surgery shall remain as their respective units within the new United Medical Administration. Responsibility is given to the Administrator to utilize the personnel of the two departments to the greatest advantage by authorizing the detail of scarce professional and technical personnel to other agencies. This provision is intended to be temporary in nature.

E. An amendment to give special provision for the orderly transfer of pertinent records to the Administrator. Responsibility for determination of rules and regulations for the maintenance of files and records required by the Administrator is vested jointly on the Secretary of Defense, the Administrator of Veterans' Affairs, and the Administrator.

F. An amendment, directing the Administrator to submit to Congress, 1 year after the enactment of the bill, a plan for the consolidation of the Public Health Service and the Department of Medicine and Surgery into a single unified professional health and medical career service. This would initially affect—and perhaps render temporary—B and D above.

Part II

Proposed Amendments to S. 2008 (H. R. 5182)

Page 3, after line 4, insert:

"GENERAL FOWERS AND DUTIES

"Sec. 3. The Administrator, through the United Medical Administration, shall have the function to—

"(1) Operating, subject to the provision of this Act and other applicable provisions of law (including the provisions relating to the hospitalization and medical and health care of veterans), the hospital, health, clinical, and research facilities transferred to the United Medical Administration by this Act.

"(2) Conducting the public health activities of the United States transferred to the United Medical Administration by this Act, and, to the extent authorized by law, encouraging, cooperating with, and rendering assistance to other appropriate public authorities, scientific institutions, and scientists in the conduct of, and promoting the coordination of, research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments of man.

"(3) Conducting the residency and internship program, provided for under section 14 (b) of the Act of January 3, 1946 (59 Stat. 679), as amended."

Renumber section 3 as section 4.

Renumber section 4 as section 5.

Page 3, beginning with the last word in line 7, "Administrator," strike out the matter down through "Air Surgeon," in line 9, and insert: "Secretary of Defense, the Administrator of Veterans' Affairs, and the Surgeon General of the Public Health Service."

Beginning with line 22 on page 3, strike out down through line 2 on page 4 and insert: "(1) the Public Health Service together with its facilities, and all functions of the Federal Security Administrator in relation thereto."

Page 4, line 3, before "all hospitals" insert: "the Department of Medicine and Surgery of the Veterans' Administration."

Page 4, line 7, before the semicolon, insert a comma and "except that there shall not be transferred to the United Medical Administration any functions relating to the establishment of eligibility of veterans for hospitalization or medical or health care."

Page 6, line 18, before the period, insert a comma and "except that where the Secretary of Defense (in the case of the Armed Services) or the Administrator of Veterans' Affairs (in the case of the Veterans' Administration) determine that certain categories of files and records are needed in the administration of functions not transferred by this Act, such files and records shall not be transferred but the Administrator, the Secretary of Defense, and the Administrator of Veterans' Affairs shall jointly prescribe rules and procedures for the maintenance of such files and records, for their ready availability to the Administrator, and for their utilization by the Administrator in the administration of functions transferred to the United Medical Administration by this Act."

Beginning with line 13 on page 7, strike out down through line 25 on page 12 and insert:

"PERSONNEL

"Sec. 6. (a) The Public Health Service transferred from the Federal Security Agency, and the Department of Medicine and Surgery transferred from the Veterans' Administration shal continue as such in the United Medical Administration.

"(b) The Administrator is authorized to detail personnel of the Public Health Service and of the Department of Medicine and Surgery for health or medical duties with any other agency of the Government."

Page 13, line 4, strike out "employees of the United Health and Medical Services" and insert: "personnel of the Public Health Service and of the Department of Medicine and Surgery."

Page 13, line 9, strike out "United Health and Medical Services" and insert: "Public Health Service and of the Department of Medicine and Surgery."

Page 13, lines 14 and 15, strike out "United Health and Medical Services" and insert "United Medical Administration."

Page 13, line 18, strike out "Persons in the United Health and Medical Services" and insert: "Personnel of the Public Health Service and of the Department of Medicine and Surgery."

Page 14, beginning with line 11, strike out down through line 2 on page 15, and insert:

"PLANS FOR UNIFICATION OF PROFESSIONAL HEALTH AND MEDICAL SERVICES

"SEC. 9. The Administrator is directed to submit to the Congress, within one year after the date of the enactment of this Act, a plan for the consolidation of the Public Health Service and the Department of Medicine and Surgery into a single unified professional health and medical career service."

JUNE 24, 1950.

Hon. WILLIAM L. DAWSON,
Chairman, Committee on Expenditures in the Executive Departments, House of Representatives, Washington, D. C.

MY DEAR MR. DAWSON: You may recall that during the course of my testimony on H. R. 5182 on Wednesday, June 14, Mr. Clare Hoffman of your committee repeatedly raised questions about that part of my formal testimony which emphasized the fact that although almost 40 percent of the effective supply of doctors were withdrawn from civilian life during World War II, "the most reliable indices of the health of the American people show improvement, not retardation."

Mr. Hoffman questioned my ability to submit data in support of this contention, but asked me to do so if I were able. I indicated during the course of my testimony that I relied on studies of the American Medical Association and the Metropolitan Life Insurance Co. for substantiation, and that I would submit specific facts and figures at my earliest convenience, which I am now able to do.

In Bulletin 73 of the bureau of medical economic research of the American Medical Association (1950) on Infant Deaths and Stillbirths in Leading Nations, by Frank G. Dickinson, Ph. D., and Everett L. Welker, Ph. D., one finds the following opening sentence, "Students of vital statistics lay great stress upon three important measures of the health situation in a nation: Maternal mortality, infant mortality, and life expectancy particularly at birth." These were the objective "indices" referred to in my statement. On page 4 of Bulletin 73, one finds the following data:

Infant mortality rates by race in the expanding registration area of the United States (deaths per 1,000 live births)

	All races	White	Nonwhite
1940	47.0	43.2	73.8
1945	38.3	35.6	57.0

In short, the foregoing data indicate an over-all improvement in the death rate for infants of approximately 19 percent during the period of World War II.

In Health Progress, 1936–45, A Supplement to Twenty-Five Years of Health Progress, by Louis I. Dublin, Ph. D., Metropolitan Life Insurance Co. of New York City, page 78, one finds the following data relative to maternal death rates:

5-year averages of maternal death rates per 1,000 live births, United States registration area (age period 10–54)

	White females	Colored females
1936–40	4.0	8.4
1941–45	2.1	5.4

This table shows an improvement of almost 50 percent in the maternal mortality rate for white females, and about 36 percent for colored females.

With respect to the third major index—life expectancy—Health Progress, 1936–45, page 9 contains the following information:

Expectation of life at birth—total persons—industrial policy holders (excluding military and civilian deaths from enemy action)

Calendar year—	*Expectation in years*	Calendar year—Continued	*Expectation in years*
1940	62.93	1943	63.86
1941	63.42	1944	64.40
1942	64.26	1945	64.95

During the period of the war there was therefore a gain of 2 years in the life expectancy among he indusrial policyholders, whose experience by 1945 was closely parallel to that of the general population.

The foregoing data seem to me to justify fully the comment contained in my original statement that the most reliable indices of the health of the American people show improvement, not retardation, during the period of the war, when 40 percent of the effective supply of doctors were withdrawn from civilian life for duty with the armed services.

During my testimony, Mr. Hoffman sought repeatedly to have me agree with his interpretation of my comment, which was to the effect that I was arguing that "the fewer the doctors, the healthier the community." This was not my contention. It is an elementary rule in logic that two factors may be associated without one being directly dependent upon the other. It is admittedly a challenging phenomenon to find such striking progress on the health front during a period when the number of doctors available to the civilian population declined so greatly. In my formal statement I indicated one reason why this decline in numbers did not have the deleterious effect that one might have anticipated. "One must contemplate the possibility that many services that doctors render in normal times are relatively unimportant and can be safely dispensed with, at least for the limited period of an emergency." During the course of my testimony, I called attention to a second important factor which contributed significantly in my opinion to increasing the "productivity" of those doctors who remained in civilian communities, namely the fact that during the period of the war an increasingly large number of seriously ill patients, especially in the more sparsely settled parts of the country, were treated in hospitals, thereby helping to conserve very considerably the time that doctors previously spent traveling to patients' homes. (See in this connection my A Pattern for Hospital Care, Columbia University Press, ch. 9.) As I recall the further discussion of this point, Representatives Rich and Harvey of your committee quite correctly called attention to another important aspect of the problem, namely, that many of the doctors who remained behind lengthened their working day inordinately. The patients were cared for, but many of these doctors became, in the true sense of the term, war casualties.

One final point may go far to narrow the seemingly wide gap in the understanding of this problem that exists between Mr. Hoffman and myself. Although the major indices point to an improvement in the health of the American population during World War II, it is possible that the rate of improvement would have been even greater than it was, had it been possible to withdraw a smaller number of doctors from civilian life. With reference to this last point, you will recall that both in my formal statement and during the course of my testimony I took the position that a greater degree of coordination and control in the medical services of the Armed Forces might have enabled them to perform their mission with a considerably smaller number of doctors, which would have left a larger number available in the civilian community.

I hope that the foregoing is a satisfactory elucidation of the point at issue. It seems to me that it indicates the shortcomings of a "common sense" point of view based upon "experience." For centuries people "knew," on the basis of common sense and experience, that the world was flat. On a common-sense basis one would assume that the more doctors, the healthier the community, but the data presented above indicate that the problem of health is much more than just a question of the number of doctors available.

I do hope that because this issue was stressed so greatly during my appearance before your committee, it will be possible for you to append this letter

to my testimony. May I take this opportunity of expressing to you and the other members of the committee my appreciation for the opportunity which you gave me to appear before you and to present my materials so fully.

Sincerely yours,

ELI GINZBERG.

STATEMENT OF DAVID D. RUTSTEIN, M. D., PROFESSOR AND HEAD OF DEPARTMENT OF PREVENTIVE MEDICINE, HARVARD UNIVERSITY MEDICAL SCHOOL [1]

I make the following statement as a representative of the field of preventive medicine in order to indicate the probable effects of the enactment of the United Medical Administration bill, H. R. 5182, on the status and development of preventive medicine in the United States. The opinions expressed are personal ones, and do not represent those of Harvard University or any other agency.

The importance of preventive medicine is stressed and given priority in the task force report and in the Commission report. In both reports it is evident that the only hope of inhibiting the continual and rapidly increasing expansion of hospital and other therapeutic services lies in the development of preventive and public health research, information, and techniques.

It would seem desirable to review briefly the historical development of preventive medicine in this country as a background for the evaluation of the effect of the proposed legislation on developments in this field.

Preventive medicine received its first great impetus through the discovery of bacteria by Pasteur. As a result of this, preventive efforts were directed primarily toward the control of transmission of infectious diseases, particularly through techniques of environmental sanitation such as the control of water, milk, and food supplies. This resulted in a striking decrease in the frequency of diseases transmitted by such means and in a great saving of life, with a particularly sharp drop in infant mortality. These activities, however, lay for the most part outside of the medical field and were the concern of engineers and sanitarians. The practicing physician, primarily concerned with therapeutic medicine for the individual, was but incidentally involved in this preventive movement; and the hiatus between preventive and therapeutic services has continued to the present day.

Early in the present century, with the successful development of immunizing procedures against communicable disease, the laboratory physician and scientist became concerned with preventive medicine, but still the main stream of therapeutic medicine continued along its separate way. In more recent years, with an aging population and the growing importance of chronic disease requiring long periods of hospitalization, attempts have been made to develop interest in the preventive aspects of clinical medicine and the application of preventive techniques to those diseases which are the main concern of the Federal Government in its hospitalization program. If these efforts are to be successful, these relatively small budding attempts must not be overwhelmed by the dead weight of leviathan organizations for therapeutic services.

During the years when preventive and therapeutic medicine were proceeding along their separate ways, it was extremely difficult to recruit qualified medical personnel for work in the preventive field. The reasons for this included: (1) the relative lack of independence of the physician working in the preventive field, in contrast with the almost complete freedom of action of the therapeutic physician; (2) medical students were emotionally oriented in the direction of therapeutic medicine, visualizing a practice of medicine similar to that which they had received from their own physician during childhood; (3) financial rewards in preventive medicine were not comparable to those of therapeutic medicine; (4) accomplishment in preventive medicine is difficult to visualize. The average physician obtains a great deal of satisfaction in curing an individual patient. It is easy to pictorialize the giving of crutches to a crippled child. It is almost impossible to dramatize for the individual the significant number of children whose lives are saved every year through preventive programs; (5) many of the positions in the field of preventive medicine were filled by retired physicians or those who had been unsuccessful in practice. This did not increase

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[1] In this statement, the phrase "Task force report" will refer to Task Force Report on Federal Medical Services (appendix O), and the phrase "Commission report" will refer to the report to the Congress by the Commission on Organization of the Executive Branch of the Government (March 1949).

the stature of preventive medicine in the eyes of the average medical student or practitioner.

In spite of these defects, it has been possible for a small, energetic group of physicians to develop preventive services which have been of benefit to everyone. It is important that they not be further handicapped in their worthy activities.

There follows a discussion of the proposed legislation in the order of recommendations proposed by the Commission in its report to the Congress:

Recommendation (1) concerns the organization of a United Medical Administration. There can be no doubt of the need for obviating the many deficiencies in the present conduct of medical activities as outlined in chapter 2 of the Commission report, nor could one question the objectives outlined in this first recommendation (letter from (*a*) to (*h*)). One could question, however, whether it be necessary to subordinate and perhaps stifle preventive services to accomplish these objectives. As pointed out in the task force report, preventive medical research and service should do away with many of the diseases for which hospital beds are now required. H. R. 5182 would accomplish the objectives outlined by the Commission, but would at the same time throttle preventive efforts with the same therapeutic gargantua which preventive medicine should minimize or obviate.

In recommendation (2), no provision is made for representation from the field of preventive medicine on the Advisory Board to the Administrator of the United Medical Administration. Instead, the Advisory Board is weighted by representatives of the military service. Those concerned with military medicine have properly confined their interest to those particular preventive problems which concern the national defense. It would not be expected that they would have interest, training, or experience in preventive services for the general civilian population. In time of war, the pressure for hospital beds created by military needs would overshadow all other functions of the United Medical Administration, including the preventive services. Such neglect of preventive services for the civilian population would be undesirable because it must eventually result in an even greater demand for hospital beds. It is necessary to maintain civilian preventive services independent of possible control by the Armed Forces.

Recommendation (3) provides for an administrative structure which once again subordinates preventive medicine and public health to the therapeutic services.

Recommendation (4) combines the administration of many groups of hospitals now separately administered. This is the great immediate need, and should be carried out without the subservience of preventive services indicated in the illustration facing page 20 of the Commission report.

It is important that recommendation (5) of the Commission be carried out as soon as possible, since it is impossible to anticipate the future hospital load to be carried by the Federal Government. Congress must specifically define the beneficiaries entitled to medical care from the Government, and prescribe how this care should be given.

The present inconsistency in policy between the Federal hospital construction program and Federal aid to non-Federal hospitals under the Hill-Burton Act should be ended, in accordance with recommendation (6).

I am not competent to comment on recommendations (7) and (8) relating to medical policy in the armed services and the necessary measures for national defense.

In accordance with recommendation (9), medical and other technical personnel in the Administration should be on a career-service basis, similar perhaps to that of the United States Public Health Service. In making this recommendation, I assume that such personnel will be concerned with therapeutic services.

Recommendation (10), providing for a survey to determine the need for emergency aid to medical schools, is not necessary at this time. The Association of American Medical Colleges, in cooperation with the American Medical Association, is conducting such a survey and legislation to provide aid has already passed the Senate (S. 1453) and is now pending before the House (H. R. 5940).

Recommendation (11), stating that the highest priority in importance should be given to research, preventive medicine, public health, and education is inconsistent with the administrative structure created by the other recommendations of the Commission. If legislation is intended to provide highest priority for these services, the administrative structure so created should be consistent with such legislative intent and should give priority to preventive medicine and public

health. The Commission report and H. R. 5182 give only lip service to such priority, and indeed provide an administrative structure which could stifle preventive medicine and public health.

It is recognized that there is a conflict of basic philosophies in the recommendations in H. R. 5182 that a United Medical Service shall include all preventive services, in contrast with the recommendations of Government Reorganization Plan No. 27 of 1950, providing for a separate Department of Health, Education, and Security. Although such basic philosophies are vital in determining the lines along which the structure of government will evolve, I believe that these considerations should be subordinated to the practical need for continued research and practice in the fields of preventive medicine and public health. This is necessary if disease, disability, and death are to be minimized and if the need for continuous expansion of therapeutic services is to be obviated.

This statement is designed to outline the importance of preventive medicine and not to propose an alinement of health, education, and welfare services; although as one who has seen the intimate relationship among education, health, and welfare I would prefer such an arrangement to one which would bury all preventive activity under an avalanche of hospital beds.

Statement of the American Veterans Committee (AVC) Regarding H. R. 5182

The national planning committe of the American Veterans' Committee meeting in Washington, D. C., on February 25, 1950, adopted a resolution concerning the Hoover Commission recommendation for the reorganization of the Veterans' Administration. The pertinent portions of that resolution which was approved unanimously appear below. AVC supports those features of H. R. 5182 which carry out the substance of the Commission recommendations for a United Federal Hospital Administration.

STATEMENT ON HOOVER COMMISSION VETERANS AFFAIRS RECOMMENDATIONS

The American Veterans Committee (AVC) firmly endorses the Hoover Commission's recommendations on veterans' affairs in principle, as spelled out in more detail below.

Without abandoning our oft-demonstrated devotion to the principles implied by our motto "Citizens first, vererans second," we have consciously endeavored to analyze these recommendations strictly as a veterans' organization, representing the interest of our members and of all other veterans, whether affiliated with a vet organization or unorganized. Like all AVC members, the national planning committee believes that those who suffered because of death or disability incurred in the service are entitled to generous treatment by their more fortunate fellow citizens. We believe, too, that the Nation has gained and will continue to benefit by its investment in the rehabilitation and readjustment of the veteran to a productive role in our society.

On the basis of careful, dispassionate review of the facts, unhindered by the persuasive temptations of power, patronage, and plunder we find the following are facts:

1. The Hoover Commission scrupulously refrained from recommending any increase or decrease in the benefits allowed veterans; they concentrated on their assigned problem of providing these services at lower cost and with less red tape duplication, and annoyance to the veteran, which the Commisison report demonstrates conclusively characterize the present VA.

2. The average ex-GI Joe will benefit more greatly than any other group of citizens if these recommendations are effected, while all citizens gain by significant savings.

3. The American Legion-led crusade against these proposals constitutes a deplorable example of baseless accusation and approval of poor administrative management unrivaled in our history. Substitution of ranting for reason and vilification for facts contributes nothing to public enlightenment nor to the welfare of their members.

Specifically, therefore, we favor the following recommendations of the Hoover Commission and urge their speedy realization:

"We support the proposal for a United Medical Administration, with power to certify veterans for hospitalization vested in the VA, provided that veterans are assured of their rightful priority. This reform will utilize more fully scarce

medical personnel, particularly specialists, assure the veteran the same or better service, and often enable treatment to take place closer to the veteran's home. It will make available to veterans thousands of empty beds now available in Federal hospitals, which cannot be used for hospitalizing VA patients under present conditions. * * *"

In short, we find that the Hoover Commission proposals generally redound to the benefit of the veteran in terms of providing more competent service more economically, without reducing the veteran's benefits by so much as 1 cent. The veteran, always excluding the professional veteran, will benefit more from the Hoover Commission recommendations than anyone else at much less cost to the taxpayer, whether veteran or nonveteran.

We salute the Hoover Commission for able public service and express our shame, as veterans, that the Legion and other organized groups of veterans have responded to the Commission's report only by lies, vilification, and other abuse.

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